Organizing Participation: An ethnography of 'community' in hospital.

by

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ABSTRACT

This study began with the question of how patient participation is enabled and constrained by day-to-day hospital care practices. Rather than drawing from prescriptive and a priori views on what should count as patient participation, replete in the current nursing literature on patient participation, this ethnography examines how the matter of participation is embedded in (organizational) practice. A first aim of the study was to provide detailed descriptions of hospital practice as day-to-day examples of patient participation. A second aim was to extend descriptions of day-to-day practice to help explain how patient participation occurs in particular ways and not in others.

Detailed examination of day-to-day practice reveals that organization is set in motion by nurses through particular forms of language. Nurses mobilize the term 'community' to organize their day-to-day work as well as patient work. Hence, community emerged as a central topic for this ethnography. I go on to explicate the polysemicity of the language-in-use which in turn reveals how both stable and ambiguous aspects of the term community are used to constitute the day-to-day. Drawing on distinctions between 'shared expressions' and 'shared meanings', the analysis shows how different performances by persons lead to the appearance of distinguishable 'figures'. For example, the apparent polysemicity of the key term 'community' allows for extensions of persons-as-individuals and persons-as-members of community. That distinguishable figures emerge from day-to-day practice underlines everyday aspects of community as an organizing device on the ward.

I also examine the particular ways in which 'community' is employed and varies across interaction of persons constituting the day-to-day. For instance, nurse-patient, patient-patient and nurse-nurse interaction all provide work spaces in which aspects of community can be produced and reproduced differently.

In studying the particular ways in which patients participate on one ward, through drawing on 'community', this analysis shows how community acts not only as a resource for nurses, but is brought into being in ways that help to produce and reproduce modes of participation in day-to-day work. What emerges from this study is that nurses deploy community as a device to detach themselves from patients and so replicate their hierarchical orientation in ways which complement wider organizing practices. Organization and community are as much devices for holding people (entities) apart as they are for holding people (entities) together. In this sense, devices, such as 'organization' and 'community', go hand in hand with performed differences, such as that of 'nurse' and 'patient'.

DECLARATION

I declare that this thesis has been composed by myself and the research reported in it is my own work.

Signed:

Maxine Mueller

Date: April 12/95

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Chapter 1

> One of us has a son who is two and a half at the time of writing. He has just been learning about Christmas. That is to say, he has been building upon and extending a set of classes that he was previously able to use with some degree of competence. He knew, for example, the names of a wide variety of animals and was able to identify people and babies both in real life and from pictures. He was then presented with an Advent calendar - one of those nativity scenes with animals and people gathered round the baby Jesus - and pronounced it to be a 'zoo'. Given his prior experience of people and animals this was not an unreasonable induction. It was, however, wrong. Explanations therefore followed which drew his attention to the culturally approved reading of the scene [Three Kings; Camels; Star of Bethlehem; Halo; Donkeys; Shepherds; Baby Jesus; and Christmas]. Other experiences related to Christmas followed - the singing of carols, the decorating of a fir tree, visits to charitable Father Christmases and finally, on Christmas day itself, presents from Father Christmas and the traditional roast turkey (Law and Lodge, 1984, pp. 233-234).

This child acquires 'understandings' about the spirit of Christmas, traditional festivities through his experiences. In the first instance this child suggests a nativity scene was a 'zoo'. With explanations and exposure to practice (Christmas activities) his former view of 'zoo' becomes transfigured to that of a 'nativity scene'. For the child, a network of activities and actions come together to depict a celebration of Christmas conveyed through language-in-use. His understandings of Christmas arise from a particular locale (site) which draw on 'shared expressions' in order to realign his 'reading' of the scene to that which was "culturally approved". As noted above his understandings are an achievement which draw from his previous knowledge (names of animals and people) and mediate with the social accomplishment of practical experiences (singing of carols, decorating a fir tree, visits to Father Christmases and presents from Father Christmas). He draws from actions of others to access their everyday understandings and learn about Christmas, as well as from the materiality of the Advent calendar. The Advent calendar, an artefact, helps to constitute his interpretation of a 'nativity scene' rather than a 'zoo'. Persons

involved in his empirical world perform meaningful activities which delineate preferred ways of celebrating Christmas in this site. This child's understandings of Christmas will inevitably shift during the year (as he continually works at understanding aspects of his world though not necessarily specifically concerning Christmas) so that, next year his experience will extend his understandings further. He is entering a *pre-figured*space (Strathern, 1991), one in which some reasonable assumptions become named as "wrong". That this parent suggests that this child's view is "wrong" underscores a gap between his understandings of a nativity scene and that of his parent.

Similar gaps appear in everyday practices. For example, existing nursing and health care literature, implicitly or explicitly, constitutes day-to-day health care practice as requiring two distinguishable groups of persons: those who are providers and those who are recipients. It follows that the interests of nurses, doctors and administrators as providers and the interests of citizens as recipients, may differ. A gap in interests appears. But this need not be accepted as 'natural' for patients have long been recognized as being 'organized out': there is already a space or a gap between providers and recipients. As a *pre-figured*space, such a gap, resonates with Strathern's (1991) view of extension, where that which is attached represents also a disconnection. And so, in reverse, detachments convey a connection such as that which exists between providers and recipients. Such is the logic of detachment. That which is excluded or marginalized from the organization (citizens) must be returned as 'patients' or 'customers'.

This is the nub of my ethnography as an organizational study. If patients are organized out, in the first place, as patients/recipients, then pleas, such as that made by Weiss (1986), to doctors and nurses to treat them as equals, on the basis of patient rights, customer care or democratic decision-making, all appear in danger of missing the point. Within the provision of health care practices a currently fashionable way in which patients are recognized as an integral part of day-to-day practice is to legitimate their involvement. Here literature focuses on the notion of patient participation. Comprehensive reviews of this literature are provided by Brooking (1986), Brearley (1990) and Glenister (1992). This literature delineates different approaches which offer themselves as

candidates for the successful attainment of patient participation (to help bridge gaps between providers and recipients). What emerges from this literature is that a variety of authors recognize patients as marginalized in the provision of health care services. These same authors identify ways in which they perceive how patients may become more involved, such as focusing on decision-making (Teasdale, 1987; Davis 1982; Roter, 1977; Reider, 1982; Lasoff and McEttrick, 1986; Waterworth and Luker, 1990), improved communication skills (Egan, 1975; Travelbee, 1971; Peplau, 1988/1991; 1962; 1987a; 1987b; Muetzel, 1988) and boosting specific forms of knowledge (Rosenthal, et. al., 1980). Some authors, for example, Szasz and Hollender (1956), stress differences in provider/recipient dyads based on asymmetries and define scales of participation. In contrast, other authors identify the cause of patients not being included in the provision of health care services as arising from a lack of concern for patient autonomy (Wilson-Barnett, 1989; Biley, 1992; Kasch, 1986; Kosnar, 1987), while others see the problem as lying with an interest in consumerism (Beisecker, 1988; Read, 1989) and yet others privilege egalitarian relationships (Fisher, 1984; 1991; Drass, 1988). In each case, augmentations of day-to-day practice pre-fix how patient participation will be realized.

Another group of authors such as Steiger and Lipson (1985) draw from Orem's (1980; 1985) conception of 'self-care' to promote their views of the legitimacy of patient participation. Here attempted justifications for a focus on patient participation include the view that chronic medical illnesses require patients to be 'active participants' in their day-to-day care. For instance, diabetes, hypertension, arthritis, chronic respiratory disease, renal disease and chronic heart failure are frequently identified in the literature as particular instances of when patient participation is desirable. Consensus among the above authors occurs in that the view is that provisions should be made to enable patient involvement. However elaborate their justifications may be, such espousals of patient participation fail to take account of a *pre-figuring* of the space in which care can be provided. What is organized out through day-to-day organizational practices cannot be simply added back.

Existing approaches to patient participation are largely prescriptive, *a priori* and do not take into consideration the multi-variant conditions of day-to-

day practice in a hospital. Current conceptions suffer from the supposition that patient participation can be achieved by changing one aspect of empirical reality (ie. boost patient information and questioning ability before contacts with doctors; developing a contract for nurses' use with patients). Such views imply that aspects of empirical reality exist in the form of a "self-contained social unit" (Cooper and Law, 1994, p. 2), and as such are discrete elements which can be removed, repaired and placed back in empirical practice. The view that patient participation is only influenced during particular forms of interaction between nurse-patient or doctor-patient dyads appears to overlook the wider constitution of day-to-day practice.

It is important to recognize that wider organizational arrangements in a hospital enable and constrain the potential for patient participation. For example, care and treatment practices precede the arrival of any specific patient to hospital and are subsequently ordered for particular patients. A patient's involvement in the conduct of these care practices has already been enabled and constrained in particular ways. The administration of medications serves as one instance. Medications are distributed in particular ways, by particular people (ie. nurses) at particular times: how medications are to be delivered and received is pre-arranged. Such pre-ordering reveals differences, a creation of space, between providers and recipients. Another form of pre-arranging or pre-ordering is exemplified by admission practices whereby patients are admitted and sorted into varying hospital wards such as surgical, medical and psychiatric (based on diagnostic categories). Only patients with specific diagnostic labels are admitted to hospital and treated. Those patients with problems which stand outside 'specialties' available within a hospital are referred to other hospitals. So, while standardization enables order for providers in a hospital, these same methods of standardization may constrain attending to particular patients (recipients) at particular moments in time.

Having drawn attention to a few forms of pre-arrangements (which providers rely on and patients are exposed to during the constitution of care practices in hospital) what emerges is that there is an overlapping of organizing care on the wards by nurses and doctors, say, with that of administrators off the ward. Administrators conduct and organizational practices affect the provision

of services on wards. Hence in order to gain understandings of care practices, it seems important to pay attention to how modes of organization of care practices evolve. I suggest this requires that a view of the organization of and constitution of care practices be problematized. Here, it is relevant to turn to organizational and management literature.

Examining organizational and management literature, Cooper and Law (1994) suggest that privileging a finished view of practice (ie. patients receive medications at 0900 hours daily; or all patients with the diagnosis of schizophrenia are admitted to the psychiatric ward) rather than examining how practice evolves, conveys what they refer to as "putting its ends before its beginnings" (p. 2). They go on to suggest that 'organization' "is shorthand for an (pretty precarious and reversible) effect generated in the patterning of relations" (p. 10). They emphasize how organization evolves through the production and reproduction of relations across time and space (Smircich, 1983a; Smircich, 1983b; Law, 1994; Munro, 1994; Morgan, 1986). It also follows that organization is an effect of particular patterns of relations rather than a stable or secure being. Such a stance underscores a particular ontological view: organization is a process of 'becoming' rather than a state of 'being'. With this view Cooper and Law (1994) emphasize the importance of a "sociology of <u>becoming</u>" rather than a "sociology of <u>being</u>" (emphasis in original, p. 2). As they note, such a view requires that day-to-day practices be detailed across organizational work practices, rather than focusing on one aspect (or location) of the day-to-day. Cooper and Law's position would suggest examining day-to-day practice. Such a view then embodies the potential to explore a range of relations which constitute patient participation in particular ways rather than others.

It is worth emphasizing the importance of such a view to an investigation concerning patient participation. To commence study with a particular, say, definition in view does little to help attain a view of day-to-day practice except in *pre-figured* ways pertaining to patient participation (to define what counts ahead of study) and that which a researcher privileges as significant. Instead, I aim to investigate how day-to-day organization occurs.

To help problematize the organization of day-to-day practices Cooper and Law (1994) distinguish between conceptions of, and implications of modes of ordering. First they discuss "distal" organization:

> So the distal is what is preconceived, what appears already constituted and known, what is simplified, distilled; it's a bit like fast food - packaged for convenience and ease of consumption (Cooper and Law, 1994, p. 3, emphasis in original) (...) The distal is constituted by action at a distance; the proximal, through action by contact (Korzybski, 1958). The distal stresses boundaries and separation, distinctness and clarity, hierarchy and order (p. 3).

They go on to contrast distal organization with "proximal" organizings:

> (...) proximal thinking views organisations as mediating networks, as circuits of continuous contact and motion - more like assemblages of organizings. What we call (in the distal mode) the boundary between organisation and environment becomes (in the proximal mode) an intervening medium, a point or line of passage for action, movement. (...) the proximal mode reminds us that organisations so conceived are really effects created by a set of mediating measuring instruments (Cooper and Law, 1994, p. 3, emphasis in original).

So, rather than taking a distal view that organization and in turn patient participation exist unproblematically, I am following Cooper and Law's distinction and asking, like Law (1994), "how it is that they [phenomena in question] got to be that way (p. 12). As Cooper and Law state:

> distinctions in the human world are not naturally given, again, they are products or effects of ordering or organising (1994, p. 4).

Hence it is important to examine how and what constitutes day-to-day practice. Cooper and Law emphasize how it is important to problematize and not take-for-granted that phenomena in question occur by other than "continuous" activity and relations (p. 3). Proximal conceptions detail a fluidity of day-to-day practice rather than preconceived "finished" and forgotten aspects of how organization evolves (p. 3). In contrasting distal and proximal notions of organization, Cooper and Law stress that distinctions between proximal and distal notions should not be taken to imply a favouring of one over the other. Importantly, Cooper and Law, drawing from Elias noted above, stress the mutuality of distal and proximal thinking. They state that "the distal and proximal are both complementary yet different ways of looking at human structures" (Cooper and Law, 1994, p. 2, emphasis in original). In this view,

then, it is important to pay attention to both 'distal' and 'proximal' views of day-to-day practice.

To investigate practice then, a research approach which starts with an examination of day-to-day practice seems fruitful. This is markedly different to existing approaches to patient participation in the nursing literature. Rather than drawing from prescriptive and *a priori* views of patient participation, this ethnography investigates instances of patient participation as constituted by day-to-day organizational arrangements in a hospital. Contrasting with current nursing literature on patient participation, this study examines how the matter of participation is embedded in (organizational) practice. Taking an organizational view suggests that there are connections among work activities of members in a hospital. Assuming that organizational practices affect and are affected by each other, it follows, as noted by Strauss, et. al., (1964), that organizing efforts of administrators and doctors affect the accomplishment of care and treatment in a hospital ward. So, the supplementary questions to the initial research question focusing this thesis were: 'How are patients participating in their care?' and 'How are nurses, doctors and administrators enabling and constraining such participation?' A first aim of the study therefore was to provide detailed descriptions of hospital practice to exemplify patient participation. A second aim was to extend descriptions of day-to-day practice sufficiently so as to help explain how patient participation occurs in particular ways and not in others.

Following these aims, community emerged as a central topic to this study. As this ethnography developed, nurses were found to talk up community as an important aspect of day-to-day practice. Nurses' language gets picked-up on by patients. What emerges is that patients extend this key term and act out or perform everyday aspects of community on the ward. In analyzing these social accomplishments, I began to see how it was that patients were being brought to participate in the day-to-day conduct of care through notions of community. And how this participation, in turn, helped create an effect of 'community'. What I then went on to study is how community, as an effect, is employed by nurses as an organizing structure and a device.

Nurses employ community in particular ways in day-to-day practice, but, other effects are also visible in patient performances. As these relations began to emerge I began to see the overall theme of this thesis as one of community. This did not entail abandoning my initial topic of patient participation. Rather I began to see that if I wanted to understand ways in which the site of my study was *pre-figured* I had to engage more seriously and more directly with issues of community. Here, contrary to modern versions of traditional theories of social order which suggest that organizations 'attach' people (entities) together, this study suggests a different view. Community is employed as much to 'detach' members, rather than, say, 'attach' nurses to patients. What emerges is that organization and community are as much devices for holding people (entities) apart as they are for holding people (entities) together.

To reiterate, in setting up the study, I avoided pre-defining patient participation. In this regard, I did not identify in advance of empirical study, a preconceived form of patient participation which I could then use as a template to evaluate what should or should not occur in day-to-day practice; contrary to the recommendations of nursing theorists (ie., Peplau, 1988/1991; Peplau, 1962; Peplau, 1990; Orem, 1980/1985; Egan, 1975; Neuman, 1982; Roy, 1976). Instead, my expectations were that the scope and potential for patient participation would be grounded in the routine contacts between recipients and providers in a hospital. Not only did I keep open the notion of patient participation ahead of the study, I also attempted to defer definitions of related terms such as expert practice.

In order to provide a detailed examination of day-to-day organizational arrangements yet provide some limits for this thesis, I trace and explore care practices with patients on one ward. I have investigated the so-called 'organizational context' in two specific ways. First, I take a wider view of organizational practices than merely those which are present within the day-to-day activities on the psychiatric ward used to examine day-to-day practice in this study. In the ward, devices used in day-to-day practice reflect devices used in a wider view of practice at this hospital (Bestcare). In this thesis I focus on one site (psychiatric ward), in order to detail how day-to-day practice both draws on and instantiates wider organizational practices. I use the term instantiate for, to me

at least, it embodies how actions reveal "both [a] medium and outcome of the practices they recursively organize" (Giddens, 1984, p. 25). Second, I take knowledge to be socially distributed and, in this respect, a reciprocity of practices stretches across distinguishable spaces of work (Berger and Luckmann, 1966). With this in mind I collected and analyzed administrators' and doctors' accounts of how they view themselves and examined these accounts to reveal some conditions which influence the conduct of care practices within Bestcare. What emerges from an extensive analysis of these accounts is that members of the psychiatric ward both draw on and create wider organizational practices at Bestcare. As I was not convinced that this would be the case in a hospital, I was careful to include such material in my study. However, my study reveals a social distribution of knowledge which suggests that day-to-day practice in one site reflects central aspects of practice elsewhere. Such overlap conveys what Strathern (1992) refers to as "merographic" (p. 73):

> (...) what looks as though it is connected to one fact can also be connected to another. Culture and nature may be connected together as domains that run in analogous fashion insofar as each operates in a similar way according to laws of its own; at the same time, each is also connected to a whole other range of phenomena which differentiate them - the activities of human beings, for instance, by contrast with the physical properties of the universe. This second connection makes the partial nature of the analogy obvious. It presupposes that one thing differs from another insofar as it belongs to or is part of something else. I call this kind of connection, link or relationship *merographic* (1992, p. 73, emphasis in original).

As an illustration of the wider idea she notes that persons may share an ancestor (sister/brother), however, each person is distinctly different from one another and their ancestors yet, share similarities.

In particular relation to the organizing of community, the central topic of the current study, it is worthwhile noting that Rapoport (1960) provides an example of an examination of 'therapeutic community'. He is concerned to examine, a pre-established interest, how day-to-day practice is constituted as informed by understandings of therapeutic community. He goes on to set up a distinction between rehabilitation and treatment which underlines how he employs a view of therapeutic community. For example, three key questions for his examination include:

> Which measures in the Unit seem to serve treatment aims? Which measures in the Unit seem to serve rehabilitation aims within the Unit? Which elements in the Unit situation serve the ultimate aims of rehabilitating the patient to the world outside the Unit (p. 29)?

Rapoport's research questions provide him with the direction or focus which the study takes ahead of his field work. Other research such as Strauss, et. al., (1964) represents an institutional focus but does not, of course, suffer from *a priori* views such as those in nursing studies. In this particular respect, there need be no difference between work of grounded theorists such as Strauss, et. al., and my approach in this study. A grounded theory approach does not pre-define central terms ahead of empirical study. Both a grounded theory approach and the open approach taken in this study emphasize the exploratory character of empirical study.

However, a grounded theory approach has not always accounted for how researchers are moved around like those they study: researchers are as *pre-figured* as anyone else in an empirical site. In contrast to Strauss, et. al., I attempt to recognize the extent to which I am also implicated by *pre-figured* spaces (discussed in Chapter 2). Importantly, I am not claiming this is uncharted ground, but, rather, wish to sensitize the reader to some differences which may distinguish a grounded theory approach from the open approach taken in this study (such distinctions are further addressed in *Appendix 1*).

The opening child's experience of re-reading a 'zoo' as a 'nativity scene' can be likened to my experience in a research site where I have some knowledge but can further enhance my understandings about practice by entering a space which is *pre-figured* by those who constitute daily activities in practice as 'meaningful'. Exposure to those producing and reproducing the scenes of everyday activities will likely be novel and engender curiosity. Such curiosity can lead me to extend my current understandings based on the similarities and dissimilarities of previous experiences. As with the child, the unfamiliar notions become familiar in association with previous knowledge and the language-in-use helps to constitute one's current experience. The key to an examination of day-to-day practice is in drawing from members' everyday understandings as they constitute meaningful activities which shape what is to be read as 'hospital practice' and enter their *pre-figured* space.

Chapter 2

Figures and perspectives: making readings of the day-to-day

Introduction

In this chapter I present theoretical views which are employed in the thesis to help unravel pre-figured spaces of the social performances of persons in a hospital ward. Such views portray perspectives of putative *figures who have gone before*. Considerations of figures who have gone before include theoretical sources, ethnographers and myself as an ex-nurse. However, it is important to note that this perspective refers to a view of theorizing that is in the making, rather than a theoretical perspective which has been established as an explicit tradition in social sciences. I am putting forth a position which is tentative and uncertain, but which is one that I see linking particular analytical devices.

Importantly, theorizing is an inherent process of any space. To guide my analysis and theorizing I draw specifically on Strathern (1991; 1993; 1994a), Garfinkel (1967), Cohen (1985, 1994), Latour (1987; 1991), Law (1994), Fernandez (1986), Turner (1967; 1985), Munro (1993a), Munro and Kernan (1993) and Cooper and Law (1994) who examine the organizings of day-to-day practice. In this thesis, I particularly draw on the notion of extension which in turn, involves notions of attachment, detachment, prosthesis and movement. Picking up on Strathern's (1991) discussion of a play between figures, I elucidate figures in the day-to-day practice of one hospital ward. Implicit in such movement is the importance of transformations and translations of various persons' identities. What emerges is that figures of day-to-day practice are created through the evocation of images and metaphors that help to formulate understandings of persons in action (performing) or persons' acting.

One such image is 'community'. In the current thesis, a focus on images of community reveals figures as performed by persons constituting day-to-day practice in a hospital ward. The appearance of a figure displays a "tension between what is concealed and what is revealed" (Strathern, 1994a, p. 1). Such tension and continuous movement underlines how figures are always in extension (Strathern, 1991; 1994a). Importantly, the appearance of figures and

their accompanied performances are linked to how spaces are theoretically informed by a viewer/witness/ethnographer. For example, a premise of the current thesis is that *persons* perform as nurses and *persons* perform as patients. Differences between persons are not intrinsic, rather their performances act as displays of multiple images which, in turn, suggest multiple readings. On this theme it is important to recognize that performance (action) is authorized but the reading and the performance (action) are not identical. It is always possible for any performance to be given an alternate reading.

Explicating movements in everyday practice, those which lead to the appearances of figures, is an aim of the current study. A person's travel from a particular place and space is enabled by others' journeys (ie. *those who have gone before*). It also follows that, as an ethnographer revisits and revises various material such as files, field notes, transcripts and documents, the way in which spaces are represented, as pre-figurements continually emerge. Such elicitation is an "invitation to 'see'" (Strathern, 1994a, p. 1) specific forms of performances. However, problems that this visual/spatial perspective raise concern issues of authority; for example, why should readers believe the reading presented by any writer? More specifically, in the current thesis, why should readers believe the reading I present? For example, on the one hand I am suggesting that it is important to take account of the visual metaphor. On the other hand, it is as crucial to give attention to the auditory sense in order to see how day-to-day practice is constituted as well as relayed to readers. Before taking up and explicating the connections between theorizing and methodologies, I present relevant ethnographic material which is referred to as discussion of this chapter unfolds.

Privileging empirical material

In the psychiatric ward that acts as the site for the current thesis, nurses were found to 'talk up' community as an important aspect of day-to-day practice. Day-to-day interaction is ordered by nurses employing community as an organizing device for the social accomplishment of practice with patients. Nurses' performances, however, leave open the ways in which community is to be read by patients. How nurses incite persons to recognize that community is important and how persons take up community *as* patients in their day-to-day activities is the subject of Chapters 3-8. What emerges from analysis of performances in day-to-day practice are distinguishable identities of persons. For example, persons constitute themselves as individual patients or members of

community (a person-becoming-patient then, moves between the figure of person-as-individual and the figure of person-as-member of community). This socially constituting process involves transformations of persons; how these are socially accomplished and produce distinguishable figures (persons as individual patients and persons as members of community) emerge from my narrative.

Daily practices in hospital are connected to what people do outside hospital boundaries in their day-to-day but do not take that form. On the ward, as will be discussed, the everyday takes its own form. Within the hospital ward studied, community is a compelling image which **holds** for nurses and patients. That within a particular ward certain aspects of practice 'hold', and others do not, aligns with Latour's (1987) discussion. Rather than suggesting that something holds because it is true, as convention has it, Latour argues that which "holds" is read as true (p. 2).

The difference, as Munro and Kernan (1993) indicate, represents not only an epistemological inversion over what is viewed to be true and why, the implications are also ontological in unpicking the relations between 'stabilities' and a social construct of reality. For example, in the context of the hospital ward investigated in the current thesis, aspects of community hold the day-to-day together; such connections can be read as 'true' because they hold for nurses and patients. Activities and networks of relations between patients and other patients, nurses and other nurses, and patients and nurses are durable and mobile in the empirical site. However, following Cohen (1985) we can assume that patients pick-up the importance of community in day-to-day activities and turn it to their own use. Hence, the effectiveness of an image of community does not depend on all patients and nurses thinking/conceiving of community in the same way.

Partial prosthetic identities and fractal figures

In recalling my concern to explicate how persons' (patients and nurses) performances produce appearances of figures and differences between persons, critical questions for the current study include: 'How do persons constitute themselves as patient and nurse?'; What constitutes day-to-day performances and appearances of specific forms of community (and figures of persons) rather than others (Strathern, 1991; 1994a); and 'What movements, attachments/ detachments, connections/ disconnections do persons make along with, what artefacts do they use to produce themselves as one figure or another?'

Conceptions of a person can be related to a number of aspects, but importantly, a person is only ever partially this or that. The perspective taken, or the viewpoint from which one stands to view, permits different interpretations of that which is seen. For example, revisiting the excerpt from Law and Lodge (1984) in Chapter 1 (p. 1), in the context of a nativity scene a baby can be viewed as Baby Jesus rather than an infant. Either of these perspectives set in motion a different series of thought. However, the figure of an infant versus the figure of Baby Jesus suggests only a partial depiction of either reading selected by the viewer/reader. Importantly, a reading of 'nativity scene' is conveyed to this child through the voice of the boy's father. Here, discourse is what helps to stabilize the preferred reading of a collection of people and animals. The boy's father has pre-figured understandings of what constitutes a 'nativity scene'.

Law and Lodge's excerpt provides an instance of multiple images and multiple readings. In relation to those persons constructing/performing a nativity scene, if one's focus is on, say, persons as Three Kings, rather than women/men decorated for Halloween, again, such a focus evokes different readings of this picture. Taken one step further for the purposes of this discussion, three men/women decorated for Halloween infers that these persons aim to be disguised. In turn, these persons work to conceal aspects of their identity in order for them to be viewed as Three Kings (ie. female/male). Such a view overlaps with Strathern (1994b) where she discusses dancers and contrasts them with aspects of their decorations which helps constitute them as dancers. She indicates that:

> a dance is only said to be a success if it becomes <u>impossible</u> to recognise the dancers; their decorations must act as a disguise, and are reckoned to have failed if the personal identity of the dancer is perceived too easily. Individuality is proclaimed instead through the decorations themselves (p. 7, emphasis in original).

In keeping with a reading of Law and Lodge's excerpt as an occasion of Halloween, that which would help to anchor/stabilize such a reading would be language-in-use such as 'Trick or Treat' rather than the mythical festive song of say, 'Away in a Manger'. Again, discourse helps create stability of the preferred reading.

Another example may be helpful to underline the significance of performance in day-to-day practice. Persons make themselves nurses and patients so that a figure of a nurse or a figure of a patient is revealed. However, this particular distinction conceals that they are persons which may be divided

by matters of interests (ie. providers and recipients). Even so, this projects only a partial view of a nurse or a patient. To view a person in hospital attire/decoration as a patient conceals other aspects of that person by which she/he constitutes her/himself as mother/father, sister/brother, niece/nephew, engineer, student, pilot and so on. In a hospital ward, a person dressed/decorated in hospital attire also conceals that they have come from somewhere else (it gets 'forgotten' with the focus in view).

Performance creates a space which focuses people's attention in particular ways rather than others. When a person is present, what is seen is a figure of a patient (with pre-figured/stereotypical associations) rather than a person (with multiple aspects of her/himself as unique). So the figure that appears as a person and comes into view is only ever partially this or that: the view one takes of another is pre-figured in particular ways. It is also important to note that the figure of a person as patient suggests that it is a whole image but an image of patient does not constitute their whole self (Strathern, 1994a; Strathern, 1991, pp. 31 - 55). Strathern employs the term "fractal" to develop the idea of how persons, although whole persons, are composites of relations with others (1994a, p. 13). In this way, only aspects of a person are performed at particular points in time and it is that performance which reveals one figure rather than others (ie. as patient, nurse, mother, brother and so on). Strathern (1994a) puts it this way:

> insofar as persons are imagined as entities with relations integral to them, they cannot be thought of in terms of whole numbers, whether as entire units or as parts of a whole. Persons act as though they have a fractal dimensionality: however much they are divided or multiplied, persons and relations remain in proportion to each other, always keeping their scale. Indeed, persons can only exist so divided or multiplied (by relations). It is as though their relationships were also themselves (p. 13).

Drawing from the visual sense attire/decoration helps provide stability to a reading of a person as patient or as nurse. Yet, it is also important to recall that the auditory sense (language-in-use) helps to constitute performance as a fractal person. Which ever figure appears "each is a version of the other" (Strathern, 1991, p. 103). In keeping with a fractal person Strathern goes on to say that:

> the fractal person appears in the <u>effectiveness</u> of those relations integral to it, and thus always as an instantiation of itself. If it turns complete relations into relations requiring completion, one way to be completed is to be seen by others. That means, first, that the person is only ever 'seen' as a (partible) extension of itself. It means, second, that it is only ever 'seen' from one side, for the

> other side of the (one) person is the (other person of the) elicitor who evokes and completes the relation. And it means, third, that everything one 'sees' oneself is one's own other side. In this world, persons eye the effects of their own extensions (p. 14, emphasis in original).

Relations then, constitute and are "seen by others" to produce and reproduce particular figures in the day-to-day. Each performance, "the form an act takes (...) acquires a specific substance and materiality in its being made present" (Strathern, 1991, p. 102). Further, it is only through enacting a particular relationship that there is an elaboration of its existence. So, a person dressed in hospital attire/decoration walking up and down the street on October 31 may be viewed as a figure of a patient, yet a different series of associations are likely when the latter figure of a patient is compared to a persons dressed/decorated in hospital attire situated on a ward.

It is important in passing to recognize another aspect of Strathern's writing above. She employs the term "instantiation" which gets across to me a sense of readings in which action conveys both how and what is accomplished. She underlines a two-way process, rather than a one-way conception of action.

Pre-figured spaces: prosthetic devices of extension

Now I address distinctions between pre-figured spaces which help to disentangle movement and the appearance of figures in the day-to-day. Gaps in our understandings give a place/space for further elaboration or understandings, they provide a place/space for extension. Extensions can be elucidated through employing what Strathern (1991) refers to as prosthetic devices. Two forms of prosthetic extensions include: the straight forward addition of; and as a medical term which provides or supplies an artificial part (ie. prosthetic limb). To be taken in turn, these two forms of extensions enable considerations for pre-figured spaces. However, one question which arises is: 'How does pre-figurement link to prosthetic extensions?'. Pre-figurement informs the day-to-day. Pre-figurement is embedded in patternings of day-to-day practice and one of my aims is to explicate it. To explain, I develop understandings through providing examples and explicating its emergence and its necessary linkage to artefacts. In this sense, I focus on gaps (what I aim to become informed about) which, in turn, reveal how such processes are linked to movement created by using artefacts/materiality. As noted above, discourse and artefacts help to stabilize particular readings at particular times (ie.

dress/decoration of a person saying 'Trick or Treat' and baby Jesus versus an infant).

One way which Strathern (1991) addresses prosthetic extension is as a mode of adding onto a figure (person), through the use of artefacts which facilitates the emerging appearance of another figure. Importantly, this involves a mechanical or materiality item (artefact) in combination with motion to produce a figure. Strathern presents aspects of Wantoat peoples' dances to illustrate a materiality which illustrates how the "(p)erfomers literally magnify themselves" (p. 63). Effigy's or "extension 'figures'" are strapped to the body of dancers (p. 63). Frames for these effigies are constructed out of bamboo poles. Such artefacts enable dancers wearing them to make themselves into "trees" (p. 64) and make themselves into "spirits" (p. 64). However, the simple addition of artefact does not lead to the constitution of identity of trees or spirits. Instead accompanying swaying and movement enables the appearance of figures as that of trees or spirits. In the following excerpt Strathern suggests the figure of a dancer changes to the figure of a tree:

> one can see him [dancer] and his towering figure like an entire tree, or see him as attached to/detached from the waving bamboo above, and in that sense created or revealed by it. (...) I would not focus attention so on the trees if it were not for the way they evoke for me another set of images (Strathern, 1991, p. 65).

Strathern's focus enables her (and her use of narrative enables readers) to see or make visible a performance of either a tree or a dancer waving bamboo. This effect is produced through the combined effort of first, this dancer with artefact and, second, Strathern's mobilization of images. Such patterns for extension are already embedded in this display. In this case, attachment of person to a pole (person holding a pole) also announces detachment of dancer/person from self and attachment to tree. As previously noted, drawing attention to examples of attachment/detachment helps to elucidate how and what produces movement as well as the effects of such social practices.

Literally a bamboo stick is not a tree nor a spirit. However, with movement performance creates a space which focuses people's attention. As noted above, "(t)he process of movement from one axis to another makes people aware of their own perceptual faculties in creating images" (p. 113). In particular, the combined relations of a bamboo stick, dancer and swaying creates a space for images. "(I)mages have to be made present" in order for persons to take action (Strathern, 1991, p. 117). This dancer's image of performing (tree, spirit or self as dancer) is made present. Images lead to performance. It is

important to emphasize how movement and performance relate to images/figures. Fernandez (1986) points to the significance of movement with "persuasions and performances" (p. 37). He states that:

> Movement is obtained by the use of metaphor for purposes of persuasion and performance (see Fernandez, 1972) and order by the use of metaphor for purposes of classification (1986, p. 37).

Fernandez suggests that personal pronouns "point at the unities of our experience" and images/figures that are predicated upon them provide "actionable identity" (1986, p. 198-199). Such postulates "formulate and stimulate experience" (p. 199). Images are asserted, performed and thereby organize considerable activity for persons in day-to-day practice (Fernandez, pp. 198-199).

Another way to consider performances of persons is suggested by Strathern (1991) when she says:

> images contain other images - the upright tree growing in the ground anticipates the inverted tree with its roots in the air. Each presents a quite specific configuration of elements, but each extends others in its effect (p. 113).

In this respect, figures are always in the process of being formed/defined by previous understandings and figures. Strathern develops the idea that the later figure is 'cut out' of the preceding figures (pp. 107 - 111; for further examples of how artefacts enable a crossing over from one figure to another, see Strathern, 1994a and Strathern, 1994b). It is also important to note the limits of available artefacts. "Each individual subject makes do with what is 'already there' in the cultural repertoire" (Strathern, 1992b, p. 8).

As discussed, understandings of performances are created through pre-figuring spaces. The use of prosthetic devices (mechanical or materiality item) are one way in which one figure is extended to another figure. The "effectiveness" of the performance depends on "those relations integral to it" (Strathern, 1991, p. 14; previously quoted). This applies to a dancer performing say, a tree, as well as persons performing patients or nurses. Extension yields different capacities and in this sense are prosthetic as in the addition of an artificial part/materiality to help make a particular figure visible. Once a particular figure is visible there is the potential for 'more' value to be gained from particular relations. Such a view cross-links with the view that 'more' value can be gained by evoking images of community in that, a person may gain more value from constituting particular relations with others: "'more' than the

obligation or protocol, [or] the social norm" (Strathern, 1991, p. 102; Bell and Newby, 1971).

I now turn to explicate how artefacts help to effect figures in day-to-day practice.

Artefacts help to effect figures

The significance of artefacts is common to anthropological studies. Another example is provided by Turner (1967). He refers to Harrison's discussion of initiation rites where a variety of important artefacts include: relics of deities, drums, musical instruments, masks, figurines, effigies, pottery and so on (p. 102). Turner emphasizes that one feature of such artefacts is "often their formal simplicity" but that their interpretation is "complex" in contrast to their "outward form" (p. 103). He discusses how difficulties of interpretation emerge from the frequency of disproportion, monstrousness and mystery. Turner elucidates how artefacts employed either exaggerate or reduce human features (ie. head, nose are made huge or tiny in comparison to body proportions) and the "outstandingly exaggerated feature is made into an object of reflection" (p. 103). The second difficulty in interpretation arises from a blurring of boundaries between say human and animal forms (ie. animal-headed gods or animal-gods with human heads). Turner suggests an account of such blurring of distinctions is:

> that monsters are manufactured precisely to teach neophytes to distinguish clearly between the different factors of reality, as it is conceived in their culture. Here, I think, William James's so-called 'law of dissociation' may help us to clarify the problem of monsters. It may be stated as follows: when *a* and *b* occurred together as parts of the same total object, without being discriminated, the occurrence of one of these, *a* and a new combination *ax* favors the discrimination of *a b* and *x* from one another. As James himself put it, 'What is associated now with one thing and now with another, tends to become dissociated from either, and to grow into an object of abstract contemplation by the mind. One might call this the law of dissociation by varying concomitants' (1918, 506). (...) Monsters startle neophytes into thinking about objects, persons, relationships, and features of their environment they have hitherto taken for granted (Turner, 1967, p. 105).

Similar to Strathern's emphasis on a reader/viewer/ethnographer eliciting images, Turner suggests such artefacts help "startle (...) thinking"/images of soon-to-be-members (neophytes) in particular ways rather than others. Turner claims that persons identified as those belonging to liminal phases (soon-to-be-

members) are urged to reflect upon "previous habits, of thought, feeling, and action" and "forced and encouraged to think about their society, their cosmos, and the powers that generate and sustain them" (p. 105). The importance of artefacts and how they help to constitute movement is also described by Fernandez (1986). He suggests that there has to be some media for movement or materiality for movement to proceed. The use of figure and metaphor are inter-changed in his writing which underlines movement from one figure to another.

Importantly, through the use of artefacts, aspects for reflection are made visible and "stand out and can be thought about" (p. 106). Through the use of mystery "the nature of things and how they came to be what they are" (p. 107) "enfranchises speculation" (p. 106). The following excerpt from Turner serves to exemplify extensions enabled by associated connections/disconnections of figures:

> The man-lion monster also encourages the observes to think about lions, their habits, qualities, metaphorical properties, religious significance, and so on. More important than these, the relation between man and lion, empirical and metaphorical, may be speculated upon, and new ideas developed on this topic. (...) there is a promiscuous intermingling and juxtaposing of the categories of event, experience, and knowledge, with a pedagogic intention (p. 106).

Here, mystery or the use of myth overlaps with Strathern's (1991) discussion of a dancer holding bamboo with accompanied swaying motion which helps create a figure of trees and spirits (see also, excerpt from Law and Lodge where artefacts used at Christmas help to transform a 'zoo' into a 'nativity scene' for a child). What emerges from the above discussion is that images are productive (effective) in day-to-day practice. For example, Turner claims that forms of initiation practices:

> both teaches the neophytes how to think with some degree of abstraction about heir cultural milieu and gives them ultimate standards of reference. At the same time, it is believed to change their nature, transform them from one kind of human being into other (p. 108).

This emphasizes that performances such as those addressed above are not merely for entertainment to be taken at face value, but, that they constitute meaningful practice for performer and viewer. For some readers the examples from Strathern and Turner may appear to be a long way off from the day-to-day in the western world. To help bridge such a view, I want to reflect on an example provided in Chapter 1.

Law and Lodge (1984) provide an interesting example which pertains to the current discussion. I want to consider relations of materiality and the developing discussion of *those that have gone before* Law and Lodge's excerpt reveals how a parent helps transform what this child originally read as a 'zoo' to that of a 'nativity scene' where his parent is a figure who has gone before. The use of one artefact, a nativity scene, language-in-use, together with other activities in December (singing of carols, decorating of a fir tree, visit to charitable Father Christmases, and the traditional roast turkey) enables this child to *pre-figure* what initially appears as a zoo to a nativity scene. A nativity scene, is, as Law and Lodge note, a "culturally approved reading of the scene" (1984, p. 234). There are preferred and pre-figured images passed on by those who have gone before. What emerges is that moving this child's reading from zoo to nativity scene is accomplished, through talking up the artefacts as aspects of the myth of Christmas. Such a myth is presented through the voice of this boy's father. The use of artefacts and myth enable the appearance of one figure (or a series of figures depending on the focus taken) then, another (or others; as exemplified in the earlier discussion of Halloween on page 1. For this boy, a donkey in a field may be read as simply a donkey (an animal) whereas, in future, a donkey with an infant is more likely to be recalled in the context of a nativity scene. In this respect, at different times figures are read and interpreted differently based on understandings from those who have gone before. Persons may attach to a range of material artefacts as they move, but, there must be a materiality of some kind (the reverse is impossible to imagine when one attempts to identify empty space): the appearance of figures and materiality work together.

As noted, an aim of this study is to reveal how persons perform as nurses and how persons perform as patients: how a person 'cuts' a figure (Strathern, 1991) of a nurse rather than that of a patient. Similarly, I was concerned with how persons produce themselves as doctors and administrators (as previously noted, the current thesis focuses on patients and nurses in the psychiatric ward). Social accomplishments of a nurse and a patient are inter-related in day-to-day practice. My concern to explicate how difference is sustained, arises, for example, when exploring the constitution of identity. As already noted, rather than examining identity and explain away or flatten differences (ie. from one nurse to another nurse), I assume difference and am intrigued by identity. In this sense, it is important to note that I make the claim that I did not pre-figure the site in terms of forms of participation. To detail

how persons produce themselves as patients and nurses I am required to identify those particular methods that persons use to constitute themselves as patient/nurse; 'when' and with 'who' else.

One example arises by way of contrast to other wards at Bestcare (the hospital examined in this study). Nurses in all other wards wear uniforms while on duty and patients wear night clothes. In the psychiatric ward nurses wear civilian dress while some patients wear night dress and others wear civilian dress. This difference in type of daily dress is important. A type of dress, like the bamboo discussed above, I read as an artefact enabling extension and identity. The use of this particular artefact reveals important distinctions that are made in day-to-day practice on this particular ward. Here Fernandez's (1986) excerpts concerning "The Parrot's Egg, The Great Hunter" are informative as he marks the significance of dress in day-to-day practice where the leader is:

> dressed in red - for it is he who takes away the sins of the members (...) The guardian of the chapel dressed in white - for it is he who maintains the purity of the night (...) (p. 195).

Reflecting on the difference in dress between persons performing patients and persons performing nurses, civilian dress can be read as a mark of 'normality' which patients can presumably move towards. There is a difference between patients and nurses signalled by their respective dress/decoration. Such a difference, invites examination. Apart from this seemingly obvious difference, however, my question is over how nurses cut and sustain a different figure from the figure that patients cut. Sustaining calls for explanation. As developed in this thesis, such a difference is linked to the figures which I explicate from day-to-day practice on one hospital ward: persons constituted as individual and persons constituted as member of community (arising from persons-becoming-patients, persons-becoming nurses). The use of artefacts, such as dress, are important signals of movements in day-to-day practice and are further explicated in the discussions in this thesis. However, these figures fade in and out of day-to-day practice as patients are treated and transformed from persons upon admission to patients as either individual or members of community. Such a process underlines an ongoing movement as persons are transformed from one form to another. In elucidating these transformations, I draw from Turner's (1967; 1985) discussions of rites of passage as well as Latour (1987), Callon (1986), and Laws' (1986) discussions of translation of interests/ enrolment which appear to be embedded in aspects of the day-to-day on one ward.

Next I turn to present aspects of how a translation of interests and practices of enrolment help to stabilize day-to-day practice, enabling readings, on one hospital ward.

Ambiguity and stability in the day-to-day

As noted, in Strathern's ontology, she suggests that there never is one figure which an ethnographer/ anthropologist can simply identify. If, as Strathern suggests, that there never is a single figure, the question which arises is why might a single figure appear. If taken to an extreme such a view implies that it is impossible for any understandings to be 'fixed' in the day-to-day. It is here that a translation of interests helps to sustain that which is privileged to be in focus and it is also here that the former 'hit and miss' scenario (ie. being unable to make a reading) is turned around in day-to-day practices of persons. Material artefacts are stressed by Law (1991; 1994), Latour (1987; 1991), Munro (1993) and Cooper and Law (1994). They all emphasize that technology is unavoidable. Each of these as ethnographers discuss how human and non-human forms are inter-related and enrolled with one another in a network of activity. In this respect one of my aims is to arrest the inter-relation of materiality of performances in the day-to-day of a hospital ward. As already noted, it is important to consider how a figure can appear as a stereotype and yet remain consistent with my previously discussed aims not to flatten persons into stereotypes (ie. all persons performing patient being reduced to one stereotype and so on).

As I have suggested, materiality/discourse, performing images of one figure or another and preferred readings of daily practice, inter-relate in the constitution of day-to-day practice. Prior to presenting these particular aspects towards the production of the day-to-day it is important to distinguish between how spaces can be pre-figured. The discussion now turns to relate how pre-figured spaces (pre-arranging/pre-ordering of spatial arrangements/with artefacts and pre-figurement of identity) help to accomplish the appearance of a figure.

Here, bringing forward discussions of artefacts help to explicate another sense of pre-figurement. Although Strathern (1991) uses pre-figuring in a direct sense I suggest that it is also important to discriminate pre-figuring in terms of pre-arranging or pre-ordering which takes into account spatial arrangements. I articulate this sense of materiality pre-figurement as an ordering or arranging of space. In this respect, it is not simply a matter of pre-arranging or pre-ordering

certain items. Rather, who does the pre-arranging and what gets pre-arranged/pre-ordered arise as significant. As already noted, "(e)ach individual subject makes do with what is 'already there' in the cultural repertoire" (Strathern, 1992b, p. 8). Hence, a question which emerges from the importance of materiality towards the production of movement, then, includes: 'What is the materiality lying around for persons to use in a hospital ward (previously discussed items include in the form a myth handed down, readings of images or narratives of a nativity scene versus a 'zoo', and so on)?'

And this is where it is helpful to relate how artefacts enable movement and, I suggest, for movement, the key idea is one of translation. Drawing particularly on Callon (1986), Law (1986a; 1986b) and Latour (1986; 1987; 1991), I now address matters of interest in social interaction.

Translation of interests

Day-to-day practice is produced and reproduced; that daily activities are sustained suggests a composite of relationships (network) in particular ways rather than others. As previously noted, part of my aim is to identify the particular types of relations which help sustain the day-to-day in one hospital ward. Posing this as a question: 'How does such a production 'come off?' In this respect, integral to accomplishing day-to-day practice there are a number of aspects presented by Latour (1986; 1987; 1991), Callon (1986) and Law (1986). For instance, Latour (1987) suggests that in order to establish a smooth running unit (day-to-day practice), a functioning network, that a translation of 'interests' must occur (pp. 108-121). Callon (1986) discusses the process of translation as one which transforms the desired interests of one person into those of another. By either account, translation helps everyone work in the same direction so to speak. Latour goes on to elaborate about translation of interests and suggests that such a process (translation) is invoked "by enroling many actors in a given political and social scheme" which involves transformations (Latour, 1986, p. 264). In this sense, he is pointing to relations between actors which effect what Turner (1967; 1985) refers to as "liminal phases" (transformations) for neophytes.

Not all persons come from the same perspective and the way in which they may like to proceed, as noted above is expected to be different. In this respect Latour (1987) is concerned with what arrests the possibility of persons moving one way or another. A translation of interests is what links persons into a network of relations: "actions of a chain of agents" "each of whom

'translates' it [plan/action] in accordance with his/her own projects" (Latour, 1986, p. 264). Such translations are critical to Latour's (1987) actor-network theory, where it is in the combined effects which produce and reproduce networks of activity. Performance of one person and performance of another person in accomplishing the overall project are different, but, they effect the success of the translation. What emerges is a highly differentiated network of activity where members are enrolled into the overall project (Latour, 1991). "Persons are separated from one another by their relationships" (Strathern, 1992b, p. 9). Importantly, Latour suggests that translation should be conducted in a way in which those accomplishing the translation ensure their own indispensability.

Following Latour, Munro and Kernan (1993) state:

> The desired effects of translation are first, *control*, in that the work of other acts to propel one's own interest and second, *invisibility* in that one's own interests can successfully be represented in the name of others (p. 2, emphasis in original).

The "invisibility" of a socially accomplished translation of interest is important to the production and reproduction of the effect of "control". Importantly, a translation of interests is not simply another way of reading coercion. A translation of interests involves innovative and sophisticated manoeuvres and relations. In contrast, coercion reduces a view of power, to "a binary structure with 'dominators' on one side and 'dominated' on the other" (Foucault, 1980, p. 142). As Latour (1991) points out "(d)omination is an effect not a cause" (p. 130). In this view a translation of interests cannot be reduced to coercion.

Integral to a translation of interests is the notion of enrolment. Consistent with Latour's (1987) discussions of actor-network theory, enrolment cannot be reduced to a discrete number of actions. Rather, it is the combined effects of practices which enable persons to see their way forward by enroling themselves in daily work patterns. It is important to note that there is no overall project, or at least if there is, none of us can 'see' it. Such a view begins to suggest how then, pre-figurement is integral to translation. Of particular interest in relation to translation is that which Latour refers to as an "obligatory passage" (1987, p. 4). Here action of others is steered through a particular point where a web of associations (interests) are drawn together. I suggest this resonates with Strathern's view of a composite of relations in particular ways rather than others. When such strategies of enrolment practices are successful (they become indispensable), socially constituted arrangements create "an

obligatory passage point for everyone if they want to pursue their interests" (Latour, 1987, p. 132). Another point about a translation of interests is that such relations/associations are expected to be economical in that, persons are working together toward desired goals. As noted in Chapter 1, typically, organization of the day-to-day "is shorthand for an (pretty precarious and reversible) effect generated in the patterning of relations" (Cooper and Law, 1994, p. 10). In any attempt to explore the processes that generate such effects, Latour (1986) suggests that researchers "should":

> (...) seek to analyse the way in which people are associated together, and should, in particular, pay attention to the material and extrasomatic resources (including inscriptions) that offer ways of linking people that may last longer than any given interaction (p. 264).

Here Latour suggests that some stability is produced and reproduced through a network of relations and activities: "ways of linking people that may last longer than any given interaction". This requires detailing material from day-to-day practice in order to explicate recursive patterns over time and space. In relation to the ward examined in the current thesis, nurses pre-figure the ways or directions (matters of interests/translation) in which patients accomplish day-to-day practice (ie. community). In this respect and in the pre-figured spaces of hospital, the identities of patients are always running ahead.

As previously noted, another important aspect of a translation of interests, as addressed by such writers as Latour, Callon, Law, Strathern and Munro, includes a view that technology is unavoidable. It is here that further stability is created in day-to-day practice through a weaving together of human and non-human (artefacts) forms. This overlaps with previous discussion where artefacts enable movement from one figure to another. More specifically, here there is a linking together of human and non-human chains of associations (Latour, 1991; Law, 1986; Law, 1994; Callon, 1986). Such relations provide a durable yet mobile configuration to work spaces. Latour's (1991) position that technology is "society made durable" emphasizes a weaving together of non-human and human fabric. Durability of the day-to-day is accomplished only through networking these typically separated aspects of empirical reality (social accomplishments). As Latour notes, a social relation or a technical relation by itself, is un-imaginable. He claims that:

> (w)e are never faced with objects or social relations, we are faced with chains which are associations of human (H) and non-human (NH) (1991, p. 110).

In particular, Latour is suggesting that consideration be given to both "human and non-human" associations in day-to-day practices.

As discussed above, Strathern, Turner, Fernandez and Latour help to create space for an examination of day-to-day practice of persons as patients and nurses in this study. Drawing from these theoretical positions of how performances of persons are constituted enables understandings of day-to-day practices of persons in a hospital ward. The two forms of pre-figuring which I explicate from this study include: pre-ordering/pre-arranging with a materiality emphasis; and pre-figuring with an emphasis on constituting identity (ie. persons as individual patient or persons as member of community).

Now I turn to present relationships between specific theoretical and methodological issues for the perspective being used in this study.

Theorizing methodologies or Methodologies theorized

As noted above drawing from Strathern (1991), performance is central to an examination of day-to-day practice. Here, the significance of performance overlaps with Garfinkel's (1967) position. He suggests the constitution of day-to-day practice can be identified by focusing on 'how' and 'what' constitutes day-to-day practice. Following Garfinkel, the perspective employed (theorizing as linked to methodologies) or that which applies to those emerging figures in a site of investigation, also applies to myself (as researcher). According to Garfinkel action/performance is read as a display. This display is a social accomplishment which contains "observable and reportable" aspects which is characterized by what actors 'do' (Garfinkel, 1967, p. 1). Performances can be obtained through viewing (observation) as well as through actors' accounts of those constituting performances in view. A key idea is that of an actor's *awareness* which conveys an actor's everyday understandings/knowledge about their actions/ performances **and** that they can provide reasons for acting as they do. In these ways actions/performances may be conceptualized as those which are accountable (observable-reportable) in Garfinkel's terms. Garfinkel suggests that accessing actors everyday understandings / knowledge are achieved through accounts which he underlines in the following excerpt:

> the activities whereby members produce and manage settings of organized everyday affairs are identical with members' procedures for making those settings "account-able" (Garfinkel, 1967, p. 1).

This excerpt also raises the importance of Garfinkel's perspective in that, there can be no difference between the conduct of each member, or would-be-

member, and that of a researcher. *Accounts* are central to 'going on' for everyone (Munro, 1993a; 1994). In other words, the importance of accounts applies to those who are being studied as well as the researcher conducting a study of day-to-day practice in a hospital. Accounts, where the auditory sense figures prominently, are performative and, as such, can be read as revealing what members know about how to go on in day-to-day practice. The significance of such a perspective underscores that there is no firm demarcation between methodologies and theorizing. Such a position also resonates through Strathern's work in that she resists such separations. In this view, and in the context of the current thesis, I obviate from time to time, what I do as ethnographer or as ex-nurse but I do not eliminate these resources; obviation need not extend to deletion or dis-memberment. Rather, in drawing on *those who have gone before* I may switch among those who inform my understandings of the current study. In so doing I am, as researcher, cutting different figures at different times. Nor, need these different figures be unrelated. As Strathern (1994a) points out, "one body [figure] takes in/brings forth another body [figure]" (p. 6) where each, as previously quoted, "is a version of the other" (1991, p. 103). Importantly though, each figure evokes a perception of relations and each figure is "cut out of or [appears] as an extension of another" (Strathern, 1991, p. 118).

Strathern offers a way of explicating such movement between figures. For example, at times I am cutting a participant, a figure of a nurse (as ex-nurse) while at other times I am cutting a figure of observer. At other times I am cutting a figure of a patient or a member of community. As Law (1994) suggests: "*I do not always want to make myself invisible*" (p. 4, emphasis in original). My attachment to one figure reveals my extension from a previous figure and also my detachment from the previous figure. What this implicates is that although at times I am cutting a figure of, for example, a nurse, this does not rule out my ability, on other occasions, to detach myself from 'being nurse', in order that I can analyze what is going on in day-to-day practice as ethnographer (drawing from theoretical resources). Like persons as patients, the movement of artefacts enable an extension of myself into different figures and a movement in and out of these figures. For me, cutting a figure as a nurse is relatively easy as I have *been there before* and have competencies of 'how' and 'what' constitutes day-to-day practice. In this respect, I am not in the position of an anthropologist who is 'new' to a field of study and has to learn how to 'go native'. As a nurse, I have

already *been there before* and such experience/competencies enable me to find out and recover how to 'do nurse' in this particular site.

Importantly, however, what I do not know either as an ethnographer or as a nurse, is what interpretations are made in this particular site. Here, Strathern also presents a way forward. In particular, she suggests that connections to something (say, figure of a nurse) are always partial. What is constituted by 'doing nurse' can only be partially understood by me. Movement across from one figure to another (ie. movement from nurse to ethnographer to patient to member of community) occurs by detaching from one set of artefacts and attaching to another. As already quoted: "one person or relationship exists cut out of or as an extension of another" (Strathern, 1991, p. 118). In this respect particular relations evoke an invitation to 'see' the appearance of specific forms which are already pre-figured in day-to-day practice of a hospital ward. Where one stands to view something, however, raises the problem of authority with regard to a theoretical position and it is to this question that my discussion now turns.

Figures of ethnography and questions of authority

Questions concerning authority to say/ document or not (to say/ document) are important to ethnographic study. In this sense, authority is linked to one's theoretical position. One way of elucidating an author's theoretical position is to identify the way in which an author places herself/himself in relation to persons constituting an empirical field. In the written form of ethnography, how an author discusses research material reveals aspects of their (my) theoretical position. However, theorizing is fraught with danger and while some authors make such theoretical stances explicit others conceal their perspective in established traditions of research. Two contrasting positions, which Strathern (1991) sees as well established in anthropology, include a representational figure and an authorial figure.

As Strathern notes, "the 'observer's' relation to 'the world'" (1991, p. 121) underlines the viewpoint of ethnographer from the site of study. Each theoretical position permits a view of, or 'place' of 'the self' of writer/ethnographer and how readings of day-to-day practice are inferred. Strathern problematizes "the person who 'went into' the field" and suggests that the authority of being present (figure of a fieldworker) "no longer convinces" (p. 8). These distinguishable viewpoints, reveal more about the theoretical perspective of the ethnographer than about that which is being

examined. Strathern's criticism of representational and authorial figures is the "elision between fieldworker, writer and author" (1991, p. 9). To representational and authorial figures, Strathern (1991) goes on to offer a third figure, which she describes as arising from narration. Each of these three figures is now discussed in turn.

A representation stance is considered by Strathern (1991) when she describes this figure as a "receptor of experience" (p. 10) where ethnographer aims to gain knowledge of "how to act as a member of that society" (p. 9). Such a figure, a "single voice" (p. 10), compiles material from a number of persons in that research site and at some later point reflects on it. This is a figure frequently conveyed through the use of metaphor where an ethnographer arrives at dawn ready to 'see the day with new eyes'. According to Strathern (1994a) "appeals to vision often serve as metaphors for greater awareness" (p. 2). A fieldworker arriving at dawn, stands ready with the new day to gain from the experiences of the natives (many voices being channelled into the receptor or ethnographer) in that site. This image is created by authors through detailing their journeys to the sites of study (ie., Barley, 1986).

Beginning a field study with the new light of day sounds like a reasonable enough endeavour. Such a stance implies that prior theorizing on the part of an ethnographer is muted as unimportant. In this respect, however, the metaphor (or figure of speech) of seeing with 'new eyes' cannot be literally true. In another reading, the metaphor of dawn is a hasty device to get past the difficulties of explicating one's theoretical position (pre-figurement). Consider: first (at dawn) an ethnographer describes/views members of day-to-day as outside of his/her productions; then the anthropologist, upon reflection, re-presents this society or culture in written form at dusk. Writing at dusk suggests that distance and reflection help the ethnographer: that theorizing enables the emergent written view of the ethnographer to be well formulated.

A critical question arises: 'How can one escape the pre-figurement that accompanies the dusk of theoretical reflection? While one can sympathize with a fieldworker's concern not to engage in 'abstract' considerations, there are acute epistemological problems. In particular, to the extent that 'revising' research material in a different space/field occurs other theoretical issues arise. The danger of 'theorizing' is one of entering a different space from the 'field' and one where an ethnographer feels less competent. It is important to recognize however that the difficulties of theorizing are disregarded but not forgotten by employing this figure and metaphor for ethnographic study. Grounding one's

view with an empty slate ('seeing the day with new eyes') approach is theoretically problematic. While difficulties arise problems of theorizing can be displaced, but not erased.

By way of contrast, the second figure of an ethnographer can be described as a person who studies within an anthropological tradition. In this figure of the fieldworker, schooled in the tradition, the depiction of a particular society or culture is viewed as correct and "draws its own position from past ones" (Strathern, 1991, p. 8). Here the authority of the ethnographer is assumed. With an authorial figure, an ethnographer enters the field, makes observational notes and then returns to "translate her or his observations into an authentic representation of the 'culture' or 'society'" (Strathern, 1991, p. 8). In this figure of a fieldworker, an ethnographer is a neutral figure ready to grasp and construct day-to-day practice of those he/she studies. Strathern's criticism of this particular figure of an ethnographer is as follows:

> The authority of having been there turns out to be no authority, but a pre-emption of authorship. Not only did the anthropologist take this role on her or himself in a quite unauthorized sense, but concealed the process by which s/he arrived at the final description in the interest of self-generating theoretical preoccupation (p. 8).

Like the representational figure, the authorial figure appears to erase the problem of theorizing. However, coming through an anthropological tradition, I suggest, is to be laden with theorizing. The counter to such a criticism is presumably that the schooled anthropologist is carrying the 'right' sort of theory. They have been schooled or trained by figures *who have gone before*

Strathern (1991) contrasts a representational and authorial figure in the following way:

> Anthropologists' preoccupations take a typical two-forked turn. They argue about how to interpret the meaning of the actions, artefacts, words and so on produced by the people they study, understood as values and qualities that people thereby represent to themselves. Simultaneously they argue about how the ethnographer represents these meanings in the art of writing (1991, p. 7).

Strathern draws attention to these figures to emphasize that an ethnographer cannot somehow sit outside of him/herself "no more nor less than the people he or she studies" (p. 7). This view overlaps with Garfinkel's position (discussed on p. 27). In this respect it is important to not rely on accepted research traditions such as that of a representational or authorial stance towards ethnography. As discussed, neither a representational nor an authorial figure of

ethnography erase the problems of theorizing and the difficulties involved with authority. Here the onus is on the writer rather than the research approach of ethnography which also acts as an invitation for readers to see.

In dealing with the question of how to escape the dusk of theoretical reflection Strathern develops the writing of ethnography in terms of narration and in so doing, provides an image of a third figure of a fieldworker/ethnographer. As the person conducting this research study there are a number of images which I have to draw from which relate to the above discussion. For instance, as an ex-nurse, I have 'gone before'. Another image which I can draw from is that I have experiences of being a member of community. Yet other figures on which I have to draw (from those who have gone before) relate to theoretical positions which I employ to inform the current study. As Strathern emphasizes, an ethnographer cannot somehow sit outside of him/herself "no more nor less than the people he or she studies" (p. 7, already quoted):

> (T)he ethnographer can no longer pretend to be a neutral vector for the conveying of information; her or his own participation in the constructed narrative must be made explicit. Anthropological narratives, it is argued, do not refer to an independent reality which can be grasped by other means but create that sense of reality in the act of narration. The only way that reality can be grasped, then, is through a medium that already has a form of its own. To be true to the nature of human interlocution, especially the interlocutionary process of fieldwork, the writer/ethnographer must invite the reader in turn to participate in what s/he participates, which is discourse (p. 7).

Here, Strathern suggests that pretences of being a "neutral vector" be set aside and instead, make explicit how an ethnographer and a reader participate in discourse. For an ethnographer, participation in discourse is not only important during the conduct of the field study but during analysis which follows such field work. This unavoidable aspect of study is not overcome by setting up a research project/research design (ie. ethnographic study). A final narrative should reflect and show: how persons in the site draw on discourse to make moves; how persons in the site deploy discourse to make others move; how an ethnographer is made to move; and how an ethnographer makes moves in the construction of text. Here again the significance of accounts arise.

As Frankenberg (1963) notes, a researcher participating in the day-to-day provides "a sense of process which you cannot get in any other way" (p. 23). What Strathern (1991) is emphasizing is that, aspects of narration are integral to

these processes. Those persons being examined, ethnographer and readers are all implicated in an ethnographic narrative. As previously quoted, she claims:

> The invitation to 'see' is an invitation to witness the appearance of a specific form, and to have in that sense elicited it (1994a, pp. 1-2).

What she suggests is, rather than discounting particular readings of one group or another (ie. authority of ethnographer over the natives, writer over reader and so on) that these multiple readings be taken into account in the theorizing process. Such a view underlines a host of readings (multiple readings) of day-to-day practice. Importantly, a methodological correction in one's view cannot simply by-pass these difficulties. So while appeals to vision as a metaphor go some way to help emphasize the importance of reflexivity/reflection "we should not forget that vision is embodied" (Strathern, 1994a, p. 2).

Strathern (1994a) suggests the more significant question to ask is: "(I)n what kinds of bodies are the eyes set?" (p. 2). As noted by Strathern, to step out of methodological perspectives for the collection of and writing of an ethnography would be as difficult as stepping outside of one-self. As previously noted, Strathern resists separations between methodologies and theorizing. She also suggests that theorizing be accounted for rather than concealing one's position behind accepted traditions (metaphor of 'seeing the day with new eyes' or as "neutral vector" schooled and authorized by coming through an anthropological tradition). Similarly, Cohen (1994) eludes to *being there*(p. 191) as "thinking selves" (p. 154), in a particular site, as significant but not as the solitary voice with ultimate authority. He suggests that the relationship of an ethnographer, doing ethnography should be re-considered. As socially constructed beings/persons, any thinking/theorizing effects and is effected by one's self. Cohen's comments support Strathern's emphasis on an ethnographer's participation in day-to-day practice and in turn, readers participation in what an ethnographer participates. That which can be seen, is seen "as an outcome of relationships with others" (Strathern, 1994a, p. 3). One's own participation does not stop at the point of 'going native' but, in the form of discourse, is continuous. This matter is now give some further discussion.

Retracing aims of ethnography

Pertaining to the aims of the current thesis, Strathern reminds the reader and emphasizes that the ethnographic experience requires one:

> to draw a figure who seems to be **more than** one person, indeed more than a person. What happens 'takes place' because it

> happens somewhere, in the presence of others, because events become interventions, the subjectivity of different persons the issue. However, these interruptions to the self do not guarantee a therapeutic return to the familiar. Rather, there is a sense of holding in one's grasp what cannot be held - of trying to make the body do more than it can do - of making a connection with others in a partial manner (1991, p. 27, emphasis in original).

Connections I make for readers with views of an ex-nurse, ethnographer or member of community are limited. This also applies to those in day-to-day practice as they work to make attachments/detachments with others in the site. In this view, ethnography implies that connections between one form of experience and another are made available throughout the ethnographic process, but that, such an attachment is only ever partial. For the purposes of discussion here, separating the ethnographic process into different phases helps to address a number of aspects of ethnography. For instance, in order to facilitate a reader's work, first, the material needs to be transported from the empirical site and made into text for analysis (ie. transcriptions as text). This aspect of study "provides the reader with a connection" to the empirical site (Strathern, 1991, p. 7). Without a particular ethnographer conducting and writing a particular ethnography, that particular empirical site would not be available for readers. Such accounts (ie. interviews, writings/ research) provide descriptions of the day-to-day. These provide invocations (Strathern, 1991), as well as evidence of how authority invested in the text is arrived at. It is worth repeating that such accounts rest on the auditory sense of an ethnographer which are subsequently relayed by narrative/text. This approach contrasts with describing activities of others which resonate with that of a representational and authorial view where theorizing is erased. The obviousness of an ethnographer making a site available to readers through written work should not be marginalized. My disconnection (distance from the site with research material) from the empirical site with transportable material is the reader's connection to the material. This appears to be Frankenberg's (1963) point when he states that a researcher "must also break off his [her] attachment to the society he [she] has studied" (p. 22).

Connections with empirical material also go further. Strathern states:

> Ethnography makes available what can be conceived but not presented. The connection is perceptible as the reader's realization of an experience (what the ethnographer has evoked for him or her) (1991, p. 7).

Here the narrative account and the importance of evocation of images, for a reader, stands out. Narration enables readers to come to terms with aspects of

the day-to-day that may be difficult to put into words ("(e)thnography makes available what can be conceived but not presented"). A writer attempts to convey a movement and focus on particular aspects of practice while simultaneously presenting and analyzing research material. Strathern (1994a) claims: "(e)mbodiment is brought from under the text, a hidden influence is made explicit, and analysis invites us to see what we did not see before" (p. 2).

In a sense, a reader cannot end up where they started from; modified or new understandings arise; and the location of place and space is brought to a reader and they are taken to some *place* else. In this way, figures are always in the process of appearing/becoming as they are being performed throughout the ethnographic process. The relevance of extension applies to readers, those constituting practice, and ethnographers. Connections to something make attachment apparent. The same holds for disconnections and detachment: apparent disconnections reveal a sense of detachment.

Other senses of attachment/detachment are important to the current thesis. For example, a relationship suggests the making of, say, two persons in 'interaction'. It also follows that a relationship suggests a distinction between two persons and thereby exposes a detachment of one person from another person: "(r)elations are created in the separation of persons from one another" (Strathern, 1991, p. 111). Another way of putting this is that "persons are separated from one another by their relationships: mother from son, donor from recipient, and so forth" (Strathern, 1992b, p. 9). In this respect, every connection reveals a disconnection and every disconnection reveals a connection: connections appear as an effect of relationships with others. In detailing, in this thesis, such aspects of the day-to-day, I am concerned first, with elucidating how and when attachment/detachment occurs, and second, with identifying the effects of such social accomplishments. Following Strathern then, I employ a play between attachments and detachments as well as connections and disconnections. Once such a view is grasped, I can go on to suggest similarities and differences among persons. I now turn to address the problematics concerning multiple images and multiple readings of everyday activities in a hospital ward.

Problematizing multiple readings

As noted, my concern to explicate how persons socially accomplish themselves as one figure rather than another emphasizes that the notion of performance is vital. Issues of performance are important for two related yet

distinguishable reasons. First, as previously noted, performances are authorized but the reading one makes and the action are not identical. This underlines how it is always possible to have an alternate reading and this point, I suggest, should be taken into account in examinations of day-to-day practice. The difficulties which multiple readings of day-to-day practice involve is a problem I have accounted for (instead of erasing/discounting) and leads to the second important aspect of performance. Here, the issue of a notional view of reality surfaces. A notional view of day-to-day practice in a hospital ward, suggests that I would have to discount difference and make each patient and nurse the same. In this respect, suggesting that nurses all perform as a nurse in the same ways, precludes examining the different ways in which nurses 'do nurse' (perform differently). Cohen (1994) offers a way through the problematic of a notional, or stereotypical, view of reality. He suggests that anthropologists should question a flattening of persons as no more than 'bearers of culture'. To suggest that persons simply accomplish cultural practices involves an exclusion of differences among persons. Cohen suggests that the idea of a notional reality discounts difference. In an effort to counteract a generalized conception of persons in everyday practice, a different question helps to allow for differences. For instance: 'How do persons make themselves appear as a patient or as a nurse?'

As previously noted, Garfinkel's emphasis and treatment of performance helps to explicate 'how' and 'what' constitutes daily practices on a hospital ward. Garfinkel suggests that what persons constituting daily practice know and understand is "massive":

> Familiar scenes of everyday activities, treated by members as the 'natural facts of life', are massive facts of the member's daily existence both as a real world and as the product of activities in a real world (1967, p. 35).

Garfinkel stresses the importance of attending to the "product" of everyday activities. In a similar way, Cooper and Law (1994) and Munro (1993) also underline the importance of examining products or effects of ordering or organizing: everyday practice in a hospital (ordinary/"familiar scenes of everyday activities") has to be understood as products or effects of ordering or organizing. However, what members everyday understandings/knowledge perform constitutes more than they are able to express. In this sense, their performances (displays) reflect what they 'do' (know) but are unable to express. That members are observable and reportable makes explicit how they are

account-able and that they have particular methods of being account-able. Such accounts are so tied to practice that they are features of socially organized occasions of their use. This point links back to previous discussion of Garfinkel's position. In particular, daily performances are displays of 'how' and 'what' grounds understandings of day-to-day practice. So, to access persons' understandings of practice, as ethnographer, I too must attempt to explicate the methods through which ('how' and 'what') persons constitute the day-to-day. As already noted however, the accounts which persons provide ('what members say') do not exhaust the connections between a person's everyday understandings/knowledge and performance. To reiterate, what persons are able to say about their activities is by no means all that they 'know' about them.

As already noted, the dialectic which emerges as central to my thesis is how persons constitute themselves in day-to-day practice: to be a nurse is sometimes to be a member of a community and sometimes to be an individual in an organization; and to be a patient is sometimes to be a member of a community and sometimes an individual in an organization. As distinguishable performances, these different figures enable aspects of the organization of self to come into focus and be thereby examined. In this respect, there is also a problem for an ethnographer: the possibility of multiple images and readings. A multiplicity of readings might look as if it prevents me from claiming an authorial view of a hospital ward. But if different readings from accounts of persons constituting practice are sufficiently stable, this allows me to follow how one figure is cut rather than another. For example, one effect of a systematic constitution of identity, as one figure rather than another is to produce and reproduce **stable** aspects of community in daily practice. This line of discussion (questions arising from how do persons make themselves as patients or nurses), requires that I examine how persons, as nurses or patients become the same. This raises a critical question: 'What methods are these persons using?'

Following Garfinkel, one of my aims is to grasp the methods used by persons in day-to-day practice of a hospital ward. In this sense, I have of course only a limited ability to identify other persons' methods, but, here multiplicity works to my advantage. As noted, I can draw from my experience as an ex-nurse to read practice, but also, as an ethnographer participating in the construction of day-to-day practice. As ethnographer, my 'self' is involved in these constructions. It also follows that, analysis of this material enables me to look at the day-to-day differently by drawing from such multiplicity. Here, I can

employ (or perhaps I cannot not employ) readings of day-to-day practice as an ex-nurse, an ethnographer, member of community and draw from theoretical sources. In this way, I am capable of reading day-to-day practice from at least these different perspectives. Such a view then, enables me to rely on plural reflexivity (multiplicity of readings) where reflexivity is to 'undo' (examine) some of the attachments apparent in day-to-day practice. Put slightly differently, I already have a multiplicity of readings which precludes me from the native (as a former nurse, a representational view) or that put forth based on an authorial view of an ethnographer. I am trying to sustain a play of both figures as I am concerned over the power play that effaces one figure for another.

Explicating performances from the day-to-day

It is important to recognize that I am not suggesting the ward in this study is typical of North America, Canada and so on. Instead of making an ethnography of community in a particular hospital stand for the whole (the United States, Canada, and so on) I aim to examine what appears as systematic in one site. Here it is perhaps worthwhile noting that it is impossible to give previous discussions about 'community', in the form of a literature review, adequate coverage. Instead, I present how and what constitutes community in one hospital ward and relate these to existing perspectives. In this way, I aim to make connections that persons in one practice setting are making. The difference between the two is important: I am not concerned to create/construct 'new' or novel connections but instead, through narrative make more explicit those connections that persons constituting practice make. In turn, I aim to make these explicit for readers. This approach underlines how I am concerned to examine practice in the making rather than ordering (or "cleav(ing) order [Law, 1994, p. 4, p. 7]) and taking-for-granted that certain phenomena do not require explanation. This is Law's (1994) point when he claims that it is important to not "assum(e) that there are certain classes of phenomena that don't need to be explained at all" (p. 10). Law goes on to develop and emphasize the principle of symmetry in that, all aspects of social practices deserve priority.

As noted, part of my aim is to help the reader make connections with the empirical site which I accomplish through providing empirical material as text: interaction from day-to-day practice is made into text. In this sense, I cannot take the reader to the empirical site so transcriptions offer a mode of transport and I have relied on transcripts of interaction. Daily interaction in the form of text illustrates moves for readers to make. Although much of the above

discussion of Strathern's work might appear to suggest she is caught in the visual metaphor, with an emphasis on 'seeing', she also stresses the importance of text which arises from accounts and is revealed in her emphasis on the narrative (Strathern, 1992b; 1991). This overlaps with Fernandez (1986) who points out that "as we well recognize in anthropology (...) we have to go beyond what is manifestly contained in the language events themselves" and "that we go much beyond the language information given" (p. 192). He asks readers ("(p)icture if you will, good reader" p. 194) to "verbally visualize" that which he is describing, and in this way, I suggest, he is evoking readers to make extensions/moves with him (p. 194). For example, he makes explicit that through conceptions of performance, and relations to images, that understandings about the "powers of extension and synthesis" (p. 7) can be elucidated. He suggests that people's extensions through the use of images reveal how they:

> hold to predications which cause them irresistibly to organize their world, insofar as they can, so as to facilitate of make inevitable certain scenarios (p. 20).

Such organizings, in Fernandez's view, are facilitated, for example, by "a strategic predication upon an inchoate pronoun (an I, a you, a we, a they) which makes a movement and leads to performance" (p. 8). As persons come upon unfamiliar scenes of the everyday they make associations with that which is familiar to them. Images enable a person to make connections. A person (pronoun) makes a connection with a predicate (a form or quality of being) which enables a shift or movement. He goes on to argue:

> the figurative actually does something to these human agents, to their relationship with others, and to their relation to their world as the figurative helps them define that relationship and that world (p. ix).

Here, in the same way that readers draw from relations made explicit/implicit in text, so do persons constituting day-to-day practice draw from figurative resources. Such performances are constituted by daily interaction which evinces the ongoing construction of identity, always (as Strathern insists) in extension. In the following excerpt Fernandez refers to this in relation to "a problem of identity":

> Constructing identities is something that humans get done all the time. To be human is to have, to one degree or another, a problem of identity for it is to have, sooner or later, a gnawing sense of uncertainty - what I call here 'the inchoate' - which lies at the heart

> of the human condition and which energizes the search for identity through predications (p. ix-x).

Fernandez's emphasis on the problem of identity and performance are also stressed by Law (1986) when he states "society should not be seen as the referent of an ostensive definition, but rather seen as being *performed* through the various efforts to define it" (p. 18, emphasis in original). Performances and constitution of identity are integral to the narrative I present for readers in this ethnographic study.

In the analysis which follows this chapter I aim to explicate such performances. There is an inter-relation between images, movement, performance and the constitution of identity of persons. Included in the transcriptions from one hospital, the form of text employed in the current thesis, are some gestural actions. However, to show gestural actions in detail on paper would supply only a representation of moves. The reader also makes a performance and in this sense he/she can step inside the day-to-day practice. In this way, the reader can experience one hospital ward as relayed through transcriptions and, as a resourceful figure they too can work out some of the methods which persons use to make themselves as nurses and patient. Readers too, are always in the process of extension, in that, they work to make the extensions that I am claiming persons make in the day-to-day. Strathern, drawing from Tyler, makes this point and describes how ethnography makes connections which in turn, readers too are enabled to makes for themselves:

> by evoking in the reader responses that cannot be commensurate with the writer's - there is no 'object' that they both grasp, for the writer cannot 'represent' another society or culture; rather s/he provides the reader with a connection to it. Ethnography makes available what can be conceived but not present. The connection is perceptible as the reader's realization of an experience (what the ethnographer has evoked for him or her) (1991, p. 7).

Questions which arise then, are 'How can we extend what is known or understood drawing from what is known/understood?' One of the aims of this thesis is to investigate how understandings of day-to-day hospital practice can be understood drawing from readings of practice which are of necessity theoretically pre-figured. As previously noted, although I can readily recover myself as a nurse I did not know what interpretations are made in the day-to-day of the ward used for this empirical investigation. Again, this re-emphasizes the problem of multiplicity and the view that there can never be one correct reading (Gadamer, 1975/1989; Cohen, 1985).

Entering pre-figured spaces

In the current thesis the terms patients, nurses, administrators and doctors are organizational categories and, from the outset, there was no reason to presuppose that participation runs either within or across these functional groupings (such as patients, nurses, administrators and doctors). In this sense, I recognize my pre-ordering/pre-arranging. I did aim to look at participation across functional groups. However, contrary to my expectation, there appears to be no sense of participation which cuts across the range of functional groups. It is also worth noting, if these organizational categories had not remained in these broad functional groupings, that I feel confident that I would have explicated this from analysis of ethnographic material. From the outset of this ethnography I was interested to pursue forms of participation or an apparent constancy in a form of participation. I did anticipate certain differences such as my interest in patients as patients, nurses as nurses, administrators as administrators and doctors as doctors. Although it may not require stating here, another aspect of my pre-figurement was that I was drawing on literature that also re-presents pre-figurement unproblematically.

As presented in this chapter, what at first appeared to be a complete impasse (not to theorize), upon reflection, indicates that pre-figurement means that one has to theorize. In this respect, I have suggested that passing from notions of arriving at an empirical site with the light of new day /fresh eyes, to notions of reflexivity as if one could post hoc think ourselves out of the spaces we previously occupied, are problematic. The image of an anthropologist arriving at dawn captures how ethnographers have often been reluctant to theorize. Such a reluctance is no doubt due to the difficulties involved in theorizing. In relation to the view an ethnographer takes, I have noted that difficulties of pre-figurement can not be erased simply with modified methods. Importantly, methodological and theoretical approaches are integral to one another and should not be arbitrarily separated in order to "cleave" (Law, 1994, p. 4, p. 7) a sense of order.

Another difficulty raised in the above discussion of pre-figurement concerns that of multiple readings. However, I have turned the question of multiplicity from an apparent difficulty into one of comparison. Overlapping with Strathern (1991), I have suggested that the multiplicity of readings can be advantageous. As an ex-nurse and ethnographer (not relying on solely a representational or authorially informed position), I am not precluded from making moves either as a nurse or a member of community and thereby am

working with competencies to make multiple readings (as a nurse, member of community, ethnographer). As discussed, I present empirical material so that the reader too, can make some of the moves through the evocation of images from the narrative. Such a complex of relations calls for plural reflexivity. Ambiguity in daily performances is expected. I aim to use a multiplicity of readings to examine and extend current understandings of day-to-day practice in a hospital ward. Through the use of multiple accounts (persons as patients, nurses; accounts to one another and accounts/interviews with me; observational material; and documents; see *Appendix 1*) I present a view of day-to-day practice. Persons in practice authorize their own performances; I am investing authority in my writing, but, not from a tradition of anthropology as a schooled ethnographer. As discussed above, I draw from Strathern's who develops narration as a significant component of ethnography. So rather than not accounting for pre-figurement or suggesting that I can by some un-imaginable way step outside of my self during the conduct of an ethnography, I retrace the ground to a question of investigating a multiplicity of images. From this position then, it is important to account for my position as writer for it is me who is describing those constituting day-to-day practice which in turn is put forth for readers.

As discussed, like persons constituting day-to-day practice in a hospital ward, as ethnographer, I too, am cutting different figures at different times. Such movement is enabled by *those who have gone before* "one body [figure]) taken in/brings forth another body [figure]" (Strathern, 1994a, p. 6.). Figures are always in extension and figures cut both ways. At different times, distinguishable figures predominate and constitute empirical reality (ie. dancer holding effigy or performing as a towering tree; person as patient; persons as nurse and so on). Persons performing are always in extension and moving from one figure to another which underlines an ambiguity of possible readings. As suggested, this raises the question of why some figures are privileged and not others. However, as presented above, movement across from one figure to another occurs by detaching from one and attaching to another. As already noted, such connections (disconnections) and attachments (detachments) and thereby views, are always partial. As distinguishable performances, different figures enable aspects of the organization of self to come into focus and be examined. Here discourse helps to create a sense of stability as figures are continuously moving. Also, movement from one figure to another is reliant on materiality or artefacts which diminishes one figure in order that another

can appear. As noted, one effect of a systematic constitution of identity, as one figure rather than another is to produce and reproduce **stable** aspects of community in daily practice. Again, this emphasizes the significance of discourse in daily practice.

Having presented significant aspects of theorizing/methodologies which inform the current study, I now present ethnographic material which enables an examination of the social accomplishment of community.

Chapter 3

Setting up for the production of 'community'

Introduction

The purpose of this chapter is to show how work is conducted within the psychiatric ward. In order to show the accomplishment of practice I examine practice where an interface between the public at large as 'patients' and paid employees of Bestcare as 'nurses' occurs: day-to-day practice on the ward. The aim of this discussion is to illustrate the provision of care and the accomplishment of daily work practices between patients and nurses.

As will be discussed community is a potent vehicle for the conduct of daily practice in this site. The production and reproduction of community, as an organizing structure, is explicated by attending to the significant language arising from daily practice in this in-patient psychiatric ward. The prevalence and penetration of community during patient-nurse interaction is shown to out last face-to-face contacts. In turn, the continuity which community provides day-to-day practice is examined. Ensuing discussions explore ways in which this type of organizing 'structure' is set up by nurses and enables patients' interaction with one another in this ward. In this way nurses and patients constitute community in day-to-day practice.

To explicate community as an organizing 'structure', observational material which captures language-in-use is presented. The emergence of key language is supported by interview and documentary research material collected from this practice setting. These three triangulated sources (observations, interviews and documents) emphasize the centrality of this organizing structure in day-to-day practice. Through maintaining a sensitivity to language and shared expressions, I show how displays of community by patients exemplify their ability to pick-up this organizing structure as that which is to be produced and reproduced. Importantly, the performances of patients represent

points of departure from the precise language of community, which nurses use as shared expressions.

Closer examination of community in this site reveals that this organizing structure works through a tension between two opposing notions. In particular, community is underpined by features of both 'stability' and 'ambiguity'. What emerges is how a sense of *motion* is created, which compounds the potential of community (whether emphasizing stability or ambiguity at any particular time) and enhances the accomplishment of work. That nurses use both stable and ambiguous aspects of community results in transformations in day-to-day practice. I signpost these *moveable* aspects of community as a discussion of daily conduct ensues. As the term community suggests, nurses generate stability through treating patients 'collectively' rather than 'individually'. Such differences will also be noted as the discussion of this and subsequent chapters ensue.

Descriptions of ward practices

A hospital philosophy statement pertaining to this ward indicates that this medium sized in-patient acute care ward strives towards "acute, short-term admission and treatment" to enable the "patient to return to the community as quickly as possible". To maintain anonymity of this site, 'medium sized' is used to indicate that the ward has a capacity for 30-40 patients. Documentary sources also indicate that day-to-day activities inside this ward are shaped by a range of treatment programs including the following:

> Individual and Group supportive psychotherapy; Chemotherapy; Occupational Therapy, Recreational Therapy; Assessment/ Psychological Testing; Computer programs to provide teaching on self-esteem building, stress management and life time management.

This quotation suggests that a wide range of activities constitute day-to-day practice on the psychiatric ward. Following Argyris and Schon (1974) however, such statements from documentary sources represent 'espoused' practices. Documentary sources, as discussed by Argyris and Schon express 'what people say they do' and are differentiated from 'what people actually do'. The important difference here is noting a difference between 'what people say' or

claim to do and that which they 'actually do' in day-to-day practice. That documentary sources express only 'what people say they do' exemplifies the tendency for these sources to be developed as one form of administrative practice by members of Bestcare. It is important to not rely on documentary sources to represent how practice is accomplished on a daily basis. Persons constituting day-to-day practice can offer another view.

Another data source which serves to illustrate 'what people say they do' is provided by interview material. The following account, illustrating what I read to be espoused-theory, provides one nurse's description of daily practice inside the ward:

> Alison: A typical shift, okay. Well I work mainly days, so we'll talk days I guess. Um, twelve hour day. We come in at seven and we have report from seven till about seven fifteen, seven thirty, somewhere in there, depending on how many patients we have. Then we do an initial round.
>
> Maxine: uh huh.
>
> Alison: Sometimes the med nurse goes on the round or she doesn't depending on the number of patients [nurse assigned to distribute medications to patients]. She might go and check her drugs right away. And due to the programming on the floor with various activities and what not we start our coffees early, um seven thirty, um, till eight for the first shift and then eight till eight thirty. We take a half hour in the morning and then um generally try and make some kind of contact with your patients prior to the doctors coming in. They usually start arriving around eight. And they are usually, the bulk of them are finished usually around noon, uh, so if there is anything, you know, to update them on or read the charts, so you have a, you know, a better idea of what's going on with the patients, so you can let them know.
>
> Maxine: ummmmmmm
>
> Alison: So, then we have our morning program from every, well every day of the week, Monday to Friday from about nine thirty till eleven and again sometimes it's a little later depending upon the number of patients who might be involved. There are different things scheduled for different days of the week. Like for example Thursday is craft day and Wednesdays and Fridays are outings and things like that. And, um, medications are given usually at the same times daily, um, nine, one, six and ten. Um, so there is a person assigned to give out medications to the ward. Um, if there any other uh, medications that your patients might be needing PRN's [at the nurses' discretion] or what not you can give them but often people just refer them to the med-nurse. She's also the one who gives if there's depos [regularly ordered by physicians and are an intramuscular, injectable medications] due for the day or treatments or

whatever, might be changing bandages. They are usually changed by the med nurse. Um, and then we, you know again, its variable depending on what your duty is for the day as to when you get to spend the most time with your patients. Um, if you're on morning activity of course that gives you a good time to assess what's going on with the people you do take with you. And again that decision is made according to how appropriate the people might be to attend. Um, if it's just an outing for coffee well of course you could take a larger selection of people, you know, perhaps someone who isn't feeling all that well could benefit from that, whereas if it's something a little bit more detailed and intense, you know, they were quite suspicious and paranoid or whatever, wouldn't um be very suitable to take them. And then that activity is usually to be finished by eleven then of course the lunches start, eleven to about eleven-forty and then the second shift goes after that. Patient's meals, uh, forgot to mention that, breakfasts are seven-thirty and about twelve fifteen and five fifteen. And then a snack cart comes up in the evening, I'm not exactly sure of the time, I think its seven thirty. Um, and again with their meals, if there is anybody that needs assistance you help them whether it's to feed them or set them up or whatever and they all come out to eat in the dining area. So by the time the staff gets back the last shift, the patients have finished their lunches. And then we have report, um, an update, a kardexing, I guess from about twelve thirty to one. And by this time the group person has come in usually around twelve thirty, um, to get the low down on the kardexing so they can find out what's happening. And um, they do group with another day staff member and that is usually from between one thirty to three somewhere in there. And I really haven't sat in a lot at all as a matter of a fact, now that we have Tina and Nora [nurses who conduct afternoon group], I'm... doing concentrated groups, I'm not really too sure of, you know, the types of groups they have. I can't give you a lot of information about that, but um, that's basically the general way the day runs. And any kind of passes or whatever for patients start after three in the afternoon and again um, you know, if their doctor gives them a pass of course that's set, ordered before they can go out. Huh um, and during all of that you might have patients on various, um, levels of observation, um we find that out again in the morning report, if you have a patient on close, which means you check them every half hour, very close, which means every fifteen minutes. And, um, of course you have to spend a good deal of your day, you know, finding out where they're at and things. Any amount of time you spend with people of course depends upon the type of patient you have, um some patients for example, really can't do much in the way of conversation. Um, so you try and chit chat with them, and things to spend time with them, some patients can't really give you much in the way of information of how they are feeling, so you just try and do things, you know, they're um, ADL's [Activities of Daily Living], basic care and things like that, to make sure they're bathed and tidied up and um, just have a general feeling of how they're doing and where they are and things like that. Then of course the ones that, um, you kind of set priorities every day, you know, if you missed somebody the day before depending upon how busy the shift was, of course, then you try and spend more time with that person, or if you're in a more

> crisis situation or are in a place to do a lot of work, some patients aren't either, you know, at a place where they really want to do a lot of work so if we have somebody that you can work with a lot, well heck I'll spend hours with one (laughter), you know its great when you have somebody who'll talk. Um, so again a lot of that depends on how the day is going and each patient themselves is to how much time you can spend, I try to see every body every day though, that I have on, my patient load and make sure to read up on their notes previous day or few days, if I haven't been here to see what kind pertinent questions I should be asking them about their care and where they're going and things like that. So, as far as general day goes that's basically it. Then of course we start our suppers again, staffs go about maybe between four and four thirty and be finished about six and then the day staff goes home any where between seven and seven fifteen. That's just sort of the general day.

Although there is much detail in the above excerpt, I provide this account to exemplify a nurse's view of a "typical" day. Alison's view however, should not be seen as simply adding to the view of day-to-day practice depicted in the documentary source provided earlier. The description of daily practice which she offers is one which has little in common with the documentary source. Alison's account offers a view of routinized work practice as constituted by nurses. She identifies and distinguishes between different types of work activities for nurses such as, the distribution of "medications" and "concentrated group" work. In this line she suggests these activities are assigned to nurses as a 'task'. Alison also indicates that a 'regular' group occurs and is managed by Tina and Nora which implies something special about this particular activity.

Another organizing feature of daily work which Alison refers to is the "morning program (...) Monday to Friday (...) There are different things scheduled for different days of the week." I suggest this account of a 'typical day' provides a nurse-centred view of daily activities (as opposed to patient-centred view). However, Alison does convey that patients have a programme or activities to attend in "our morning program" and "morning activity". Alison suggests that nurses occupy themselves in particular ways and patients occupy themselves in particular ways. I will refer back to aspects of this account as this chapter evolves.

Alison's view of daily practice illustrates ongoing activities or sustained conduct in this ward. In relation to the flexibility which nurses perceive during

their day-to-day work, nurse Jennifer refers to "leeway" in an interview with me:

> Jennifer: Some things you don't have any leeway with, like times you come for report, times you give medication, kardex, morning programme, afternoon programme, groups, patient appointments. You do have some leeway when you spend time with your patients. Like Monday or Fridays, if you work days, a good time is usually first thing in the morning, before they go to programme or after the afternoon group, say about four p.m. So ... visiting hours start at three so sometimes you have to talk to your patients in between visitors, meal times. And nights, I don't work very many nights but then you're sort of less hampered by schedules and doctors visits that you can sort of pick and choose what patient I'll sort of see first and how much time you're going to spend with them, type of thing.

Nurse Jennifer claims that nurses "have some leeway" but counter balances such leeway with a list of defined activities such as "report, times you give medication, kardex, morning programme, afternoon programme, groups, patient appointments (...) visiting hours (...) doctors visits" (see Table 1, p. 51 for a presentation of day-to-day activities on this ward). She suggests that there is a "programme", and "afternoon group" for patients. Explicit here is that the activities which nurses conduct are distinguishable from the same activity and the ways in which patients are involved. These prescribed activities account for large portions of each day. Jennifer also states that nurses "pick and choose what patient(s)" they spend time with, outside the rigidly defined schedule of the weekdays. I suggest this excerpt conveys two important aspects of day-to-day practice. First there is a minimal amount of leeway in nurses conduct. Second, nurses' routine work practice is discernible from patient involvement in day-to-day practice.

To augment nurse accounts of daily affairs on this ward a description of day-to-day activities from a patient's perspective is presented to convey a patient-centred view:

> Sasha: Ah, well I get up ... shower ... get dressed and make my bed. I get rid of dirty towels and pick up clean ones from outside the room there by the nurse's station. Breakfast comes and we eat out there together.. I like to smoke after breakfast and ah... maybe nap for a while. (laughs) Have another smoke and like ... roam around and visit. We have lunch. (...) play crib in the afternoon with those out there, there are some of us that play all the time with one another. Ah, nap in afternoon if there is not too much company. (...) work on puzzle ... sometimes read the paper... smoke and have

> supper. Like play crib until have company and visit .. we played crib until ten o'clock last night. Ah, last night chat with others after they got back from weekend and bedtime ah, around ten-thirty. . . . This morning had community meeting and we played a game. I enjoyed it ah, we had exercises .. breathing in and holding your breath, stretching legs.. it's relaxing and we had some juice, I liked the juice downstairs. I got use to the people and activities in here .. it would be disappointing to miss them after I go. We get use to one another... by conversation. It is kinda interesting to find out about this one and that one...we all talk at the big table. When I came in they were all nice to me they invited me to sit with them...it really gave me a good feeling. (...) when the nurse told me that I have to do all this I thought "Oh my gosh". Then I thought it was a good idea, you've got to do something; but I know they don't do it in other parts of the hospitals ... ah, it gives you something to do rather than just sitting. (...) the differences are that you do your own laundry, ironing, keep room clean ... because the other parts of the hospital the cleaning lady does all that. My sister was up and she thought it was good, you know, it keeps your mind off other things (...) When I was admitted they said: "Hi Sasha"... just as if we'd known one another for years. I was greeted by a nurse and told about the regulations about rooms and everything ... I said that's a good idea, keeps you doing something, then I started getting acquainted with the other women. I just came out and started walking around and they greeted me...talk to each other. I like it in here.

Patient Sasha's conception of a typical day contrasts with nurse Alison's account. In particular, Sasha's account emphasizes her activities with patients rather than with nurses. She states: "we eat together; roam around and visit; we have lunch; play crib with those out there; chat with others after they got back from weekend"; and "this morning we had community meeting". Sasha suggests that day-to-day activities are 'different' in this ward when she says that she "got use to people and activities here". She also remarks that such activities are not those common to other wards in Bestcare when she state: "I know they don't do it in other parts of [the] hospital". Sasha informed me that during the recent 20 year period she has been admitted to three different wards at Bestcare where day-to-day activities are dis-similar to those in her above description.

Alison and Sasha's accounts represent 'typical' accounts from nurses and patients in a variety of ways. For example, nurse accounts and patient accounts discriminate between the type of work for nurse activities and patient activities while portraying a usual day inside the 'same' territory: the 'ward'. Nurse and patient accounts also exemplify that routines and rules, made explicit as

Table 1: DAILY SCHEDULE

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
Morning report ... Patient breakfasts Nurses coffee break	Morning report ... Patient breakfasts Nurses coffee break	Morning report ... Patient breakfasts Nurses coffee break	Morning report ... Patient breakfasts Nurses coffee break	Morning report ... Patient breakfasts Nurses coffee break
Medication time	Medication time	Medication time	Medication time	Medication time
Community meeting	**A.M. Activity**	**A.M. Activity**	**A.M. Activity**	**A.M. Activity**
Nurses lunch ... Patient lunch Nurses lunch	Nurses lunch ... Patient lunch Nurses lunch	Nurses lunch ... Patient lunch Nurses lunch	Nurses lunch ... Patient lunch Nurses lunch	Nurses lunch ... Patient lunch Nurses lunch
Medication time Kardex Pre-group	Medication time Kardex Pre-group	Medication time Kardex Pre-group	Medication time Kardex Pre-group	Medication time Kardex Pre-group
Group	**Group**	**Group**	**Group**	**Group**
Post-group	Post-group	Post-group	Post-group	Post-group
Afternoon report	Afternoon report	Afternoon report	Afternoon report	Afternoon report
Visiting hours Medication time	Visiting hours Medication time	Visiting hours Medication time	Visiting hours Medication time	Visiting hours Medication time
Nurses supper ... Patient supper Nurses supper	Nurses supper ... Patient supper Nurses supper	Nurses supper ... Patient supper Nurses supper	Nurses supper ... Patient supper Nurses supper	Nurses supper ... Patient supper Nurses supper
Night report	Night report	Night report	Night report	Night report
Medication time	Medication time	Medication time	Medication time	Medication time

"regulations" by nurses to Sasha, assist in shaping the activities of day-to-day conduct inside this setting.

Nurses' language-in-use

Language is a key to the accomplishment of day-to-day practice (Gadamer, 1979; Lyotard, 1984; Foucault, 1972; Foucault, 1973). Importantly, as a certain form of words are used, so they are likely to have effects in particular ways. Language has a materiality which is not only representational, it enters into organizing day-to-day practice on the ward. In contrast to the interview accounts above, I now turn to examine daily interaction between nurses and patients. Interaction constituted by patients and nurses includes what are identified by nurses as "one-to-ones", "community and ward meetings", and "groups". These forums are now opened up for examination.

The first type of interaction between patients and nurses to be addressed is what nurses and eventually patients refer to as "one-to-ones". Nurses claim that all patients receive 'one-to-ones' as a routine practice. As the term suggests, such interaction represents a face-to-face contact between one patient and his/her assigned nurse (ie. the nurse is identified by name and is expected to be responsible for that patient during his/her duty shift). Such occasions represent one way in which nurses claim they employ "primary nursing" and provide "individualized care" in day-to-day practice. During interviews with nurses their claims about one-to-ones include the following: "it is very important to treat patients as individuals"; "they are different, they are people, they're individuals and we do one-to-ones with them"; and "we all do it, do it all the time". These comments suggest that nurses value and stress individual contacts with patients. Nurses Alison, Zana, Jennifer and Nora refer to one-to-ones during accounts provided on pages 47, 54, 115 and 119 respectively.

However, when I ask nurses during interviews 'what gets left out when it is busy', all nurses indicate that "the one-to-ones" are set aside (see also Alison's account, p. 47). For example, one day I asked nurse Leona about one-to-one interaction with her assigned patients and she provides the following post-hoc account:

> Leona: Lance is awaiting placement and did not need extensive one-to-one. Bertha is a long term schizophrenic who refuses one-to-ones ... is as stable as she ever gets so, don't do one with her. A couple more that might be closer to discharge.... yesterday I did not see two and they were discharged..I didn't see them at all (chuckles) ... No, it varies from patient to patient.

I read Leona's chuckling here as a signal of incongruity with what she is saying and that which she previously stated in relation to the "import(ance) of one-to-ones". It is laughable that all patients do not receive one-to-ones with nurses. During an interview with me nurse Zana also suggests that one-to-ones are important. Zana also provides an account of when they are left out:

> Zana: (...) usually [the] one-to-one is left out. We check on them just to make sure they're okay, not in any crisis situation (...) um and that could be because we are having a lot of admissions and discharges, sometimes the one-to-one ... uhm, we'll still always check on them to make sure they are here on the ward and that they are not in any great danger. Um, that they are looked after in that respect.

Zana stresses that although the one-to-one may be left out of nurses' daily work, nurses "check on them just to make sure they're okay". This suggests that there are other ways of determining whether a patient is "okay" and therefore, one-to-ones are not deemed essential in day-to-day practice and becoming familiar with each patient.

Nurse Nora recounts one doctor's recent expressed view of one-to-ones conducted by nurses on this ward. She relays an account to other nurses, during a coffee break, which she had had with Dr. Baldwin a few hours earlier. Dr. Baldwin is a doctor who has been working in Bestcare for several years:

> Nora: Dr. Baldwin, yeah what a guy, you know, he asked me today if he wrote an order, would someone do a one-to-one with Mrs. Clemmer?
>
> Naomi: What?
>
> Nora: He doesn't think we do one-to-ones. I told him we all do it, do it all the time, he raised his eyebrows (raises her eyebrows) and left the ward.
>
> Naomi: That guy I don't know about him.
>
> Daphne: Aaugh, he can be a real jerk. . . . Was he joking Nora about the one-to-one?
>
> Nora: No, he was quite serious. He thought he should write an order for that.

One reading of this alleged exchange is that Dr. Baldwin doubts that nurses conduct as many one-to-ones as they claim is standard practice. Alternatively, Dr. Baldwin may be unaware that nurses consider one-to-ones a routine practice in their work with patients. But, Nora infers, and others present imply, that doctors ought to 'know' this. This being the case, Dr. Baldwin is not familiar with the routine activities which nurses take-for-granted or surmise as obvious. Nurses suggest that he is a "real jerk" for asking whether if "he wrote an order" this would facilitate Mrs. Clemmer having a one-to-one.

Although nurses espouse attending to patients through face-to-face interaction such findings are not borne out in the ethnographic material. Contrary to nurses' espoused views, one-to-ones are a luxury. The practice of a one-to-one is dismissed when nurses constitute themselves as busy and at other times nurses do not perceive them as 'necessary'. I am not suggesting that nurses do not have understandings of each patient, just that such understandings are not gained through conventional means, such as one-to-ones. Nurses conduct much of their work at a distance from patients. I now explore "community meetings" and "group" as another form of nurse-patient interaction and its significance on the ward.

Nurses day-to-day activities with patients are referred to by nurses in a variety of ways. One regularly scheduled activity, which nurses identify is "community meeting". Community meetings occur on a weekly basis and nurses ask patients to attend. The following excerpt is taken from one such meeting as nurse Leona speaks to eight patients who are congregated in a common room within the ward:

> Leona: policy or treatment, or tell you a little bit [audio tape cuts in and out] a little about in-patient psychiatry so you have a little better understanding. Monday's you come to Community Meeting and after this we go downstairs and learn some relaxation techniques ... and I told Sasha [a patient on ward] I always fall asleep so it is her job to keep me awake (laughs) and on Tuesdays we do crafts together ... and on Wednesdays is an outing and its your choice. Sometimes they go to the park, sometimes bowling, last week they went to the parade, its your choice. And these are all important things like don't think "Crafts, big deal?" They are important things because they give you an idea of how you're interacting with other people they give you an idea of how you're doing in the community... it's very safe and secure here on the ward and it gives you a good idea to see how you're functioning, how your feeling being around

> other people doing things. So it is important. . . And then on Thursday we do baking and you choose what you're going to bake. Usually with baking there is time to do some games and things too.

This excerpt illustrates, and is used here to single out, key expressions in day-to-day practice on this ward. Two different connotations of community are depicted above. In the first case, Leona makes explicit that patients are currently located in "community meeting". This suggests a specific activity in a particular location. In the second case she draws attention to safety and security which she correlates to "functioning of (...) the community" inside this ward. This second use of community portrays a social-ness or interactive quality among persons on the ward. These two uses of community (a noun and an adjective) raise questions of what Leona intends to convey to patients and marks an ambiguity in her use of community. Other associations reflected in this strip of interaction will be raised for discussion later in this chapter. For now my aim is to single out common expression(s) in day-to-day practice on this ward.

In another activity, a nurses' ward meeting, the Head Nurse stresses the day-to-day activities in which patients are involved:

> Naomi: (...) yeah, the programming is just the same you guys as if they [patients] were in the community and had a job. Yeah, I'm adamant about that, their job here is to attend the community activities and it prepares them for the community outside the hospital.

Naomi's language elicits the use of "community" three times in the above turn of speech. The first use of community suggests a location. The second use, a scheduled event while the third suggests a sort of life-as-usual (Garfinkel, 1967) "outside the hospital". I suggest that these three different connotations of community reveal ambiguity in the way that Naomi understands and conveys community to other nurses. Irrespective of the ambiguity, Naomi goes on to point out that she is "adamant" about patient attendance at these "community" or "programme" activities. She claims that attending community activities is the patients' "job". Language centres an important notion, community, for Naomi. That she is the Head Nurse, may or may not underscore the centrality of community in day-to-day practice. Naomi and Leona's references to "the community" suggest community is employed by nurses during interaction with patients and with one another. It would appear that "community" is a shared expression for nurses.

Another activity nurses engage in routinely, "kardex", offers other opportunities to examine language (noted by Alison, p. 47). During this routine session among nurses, particular programme events are referred to. Such activities are identified by name such as "morning activity" or according to the particular type of activity such as "baking". Nurse Alison refers to the activity of "baking" and "an outing" during her account of a "typical" day. Other community activities which Leona identifies include: "relaxation techniques"; "crafts"; "outing" (referring to an activity outside of Bestcare; going to a park, bowling, parade and so on); and "games".

As these terms are used in day-to-day activities on the ward, they do not only stand for opportunities for patient involvement but rather are treated as therapeutic activities. Terms like "baking" and "outing" are attached to the therapeutic regime on this ward. For example, nurse Tina comments on one female patient who is being discussed during kardex:

> Tina: She was up this morning and down to baking and I don't know how she did down there?

Here, "baking" is the activity under the rubric of community activities. This activity is also one which nurse Leona mentions during "community meeting" referred to on page 55.

Nurses also identify this shared expression during interviews with me. In the following excerpt nurse Leona refers to "community" as she is describing a work day:

> Leona: (...) ah in the morning the main contact with patients is during the activity, that happens between nine-thirty to eleven. Ah today we had one with nine patients and one other nurse was there also. It was, first a community meeting. This is for planning and also a time for them [patients] to get familiarized with the ward, what expectations are of them and that sort of thing. Sometimes their concerns can take a long time because of the mix of patients with adolescents and music too loud for the other patients and that sort of thing (...).

The above instance illustrates how community is used by Leona. She explains that "community meeting" is a 'planning' session for patients and that it enables patients "to get familiarized with the ward". Leona states activities are "the main contact with patients". She implies that community meeting is beneficial for patients in that they have this opportunity to pick-up on "what

expectations" guide their future conduct. Leona goes on to provide an example of what nurses claim to encourage at such activities relating to patient concerns. From previous interaction with me, Leona had indicated that "community meeting" is a time for patients to "express their concerns from the previous week" (ie. elderly patients expressed concern that younger patients were playing music to loud). Above she appears to talk on the basis that I recall our interaction and continues to imply a two-fold intention of community meetings. Firstly, patients identify their concerns and secondly, that nurses outline their expectations of patients. In this way nurses and patients constitute the day-to-day.

In another case, information was given to me to depict day-to-day activities pertaining to this ward. Naomi (Head Nurse), claims that nurses' expectations of patients are clearly documented in a patient information booklet available from the ward. Other nurses also drew my attention to this document. Some of the details included are as follows:

> Every Monday at 9:30 a.m. patients together with Ward Staff plan the recreational activities for the week. This is also a time to express your concerns or seek clarification about ward rules. Attendance at this meeting is expected.
>
> Your own clothing and shoes are worn in the hospital unless otherwise ordered by your physician. Recreational activities take place indoors and outdoors; therefore, suitable clothing and footwear should be brought to hospital;
>
> You are responsible for collecting your meal tray and returning it to the food cart at the end of the meal;
>
> Following an assessment period, an individualized plan of care is developed in consultation with the treatment team. . . . You are expected to participate in determining and achieving the treatment goals. You play the most important part in your care. Participation in scheduled activities is also expected. Activities are an important part of your treatment. We believe that your family is an important part of your treatment. Your primary nurse will talk with you about a possible family meeting.

In addition to this documentary source, information boards around the ward outline similar expectations/rules for patients during their hospitalization. These sources of information can be used by nurses to direct and legitimate nurse instructions to patients. The community of the ward is advertised as a special place enabling special opportunities for patients. Community activities are treated as therapeutic activities: "(a)ctivities are an important part of your

treatment". This document indicates that Monday's meeting (community meeting) is a "time to express your concerns or seek clarification about ward rules". Attendance "is expected" and that patients utilize this session to "seek clarification about ward rules", conveys a controlled (stable) sense of community in practice.

A range of material has been presented to show how "community" is employed as a shared expression for nurses in their day-to-day activities on the ward. Nurses advertise "community" during face-to-face contacts with patients and community activities are a reference point for nurses' discussions with one another. As discussed by Cohen (1985), it is important to note that I am not suggesting that any uniformity of meanings are attached to "community" as a shared expression.

The social accomplishment of community

Having illustrated how aspects of community are employed by nurses to constitute a central property of day-to-day activities in this ward, I now examine day-to-day practice in order to suggest what such language-in-use accomplishes. Day-to-day activities represent important work activities. In simplistic terms, a functionalist assertion that work occurs to complete various tasks ignores important aspects of what is accomplished and effects which particular terms in use have. It is important to examine how particular activities are productive and what is accomplished rather than assuming that that which is intended is that which is accomplished (Cooper and Law, 1994; Giddens, 1984). Although face-to-face contacts between nurses and patients represent important activities, it is not sufficient to merely suggest they are productive towards the accomplishment of intended care practices. Instead, it is important to examine routine activities to explicate the effects and products of daily face-to-face contacts. My aim is to show that an extension of the key term used by patients reveals an effect of the language-in-use by nurses.

In order to proceed with such inquiries, I explore instances where I propose that the accomplishment of community is being enacted. In turn, these instances are used to explicate some of the effects and products creating a range of actions constituting such interaction.

Nurses' handling of activities

Both nurses and patients informed me that nurses schedule daily activities for patients. Organized events do not simply exist but they are brought-into-being as a social accomplishment. It is important therefore to examine how such organizational arrangements take shape and what is entailed in such activities 'coming-off'. In combination with aspects of ambiguity already discussed, stability is also created by nurses use of community. Stability is engendered by nurses enclosing patients as a group through daily scheduling of activities. Day-to-day practice is also sustained where an organizing structure creates stability through the consistency of nurses in the ward while this stability is offset by patients who come and go from this ward. What emerges is that practices in the psychiatric ward appear to be 'stable' over time while different patients are coming and going. However contradictory and ironic, to espoused versions of nursing theories and models such as Peplau (1991) and Orem (1985), individual patient's do not appear to have an impact on the sustained conduct of day-to-day practice (community). I suggest that the organization of particular activities represents a 'stability' of the day-to-day affairs for nurses and patients on this ward. Latour (1991) and Law (1986) identify such effects as "durable" (p. 103 and p. 250 respectively). In this section, I unravel distinguishable aspects of how activities are handled by nurses including how nurses obtain patient attendance and what happens if patients do not attend.

As nurse Leona describes her morning routines she refers to 'organizing the patients in': "get patients and let them know about the programme". This view is revealed by nurses daily conduct and described below by nurse Leona in terms of an "expectation":

> Leona: (...) don't force any of them but we expect it, it is part of their treatment. Some never do go down, they are resistant, ... other patients encourage patients to go down. Let them know that we expect it of them. I had one that didn't come today and it was a passive resistance, he went to sleep and when we returned I woke him up and told him that "We had missed him" It was a very obvious passive refusal, he knew it was an expectation.

Leona recounts that she told this patient that "we had missed him" at this particular activity and that she claims "he knew it was an expectation". This

patient's absence from this activity is not apparently employed as an opportunity for Leona to have an interaction with this patient but rather, as an opportunity for her to inform him that she is aware he was absent.

On this same day, Leona passes this information along to other nurses during kardex. Attendance at community activities is consistently noted by nurses and non-attendance is also marked by nurses. A patient's absence or not attending is not merely 'absence' but a negative 'presence'. A patient's 'presence' is monitored, recorded and passed along to other nurses. The effect of 'presence' is revealed when a patient misses a community activity as nurse Leona illustrates on this occasion during kardex:

> Leona: Gavyn [patient] was reminded about AM activity twice and he conveniently fell asleep so, he passively refused, he slept until noon. . .

This exemplifies that patient attendance is important: it is used by nurses as a measure of a patient's willingness to 'get better'. That "Gavyn was reminded" reveals that attendance at the "AM activity" is an expectation of nurses. In this case, the nature of the non-attendance combined with "conveniently fell asleep" is translated (interpreted) for other nurses as "he passively refused". This patient's 'refusal to attend' is not merely absence but a negative presence. His absence is not accepted as legitimate. Once patients are a member of community, they cannot be absent. Instead a patient's absence is a 'negative presence'. I suggest this underlines nurses' view that in order for nurses to be able to 'move' patients around they must be present. In other words, nurses can not penetrate patients when they are not present at activities which are treated as therapeutic occasions. Hence, proximity of patients is important. As previously noted nurse Leona claims activities constitute "the main contact with patients" (p. 56). Some effects of such 'negative presence' for patients will be re-visited in Chapter 4 and 5. For the present I aim to further explore nurses' views.

The strength of nurses' expectation of patient attendance at community activities, is illustrated by nurse Alison while discussing patient Crystal, also during kardex. In this case, Crystal's actions are framed in terms of her non-attendance at "community meeting":

> Alison: oh yeah, and like she wasn't even going to come because she was laying on her bed again and when I went to wake her up a second time and I just said "Listen, ah we want to see you out there!" . . .

Alison performs what she said to Crystal, here reported to other nurses, and indicates her conviction of the message that attendance is sanctioned. This example and the previous example with nurse Leona illustrate that nurses utilize reminders with patients to reinforce attendance at community activities as virtually compulsory. The foregoing examples show how community activities are employed by nurses to schedule a patient's time on this ward.

I suggest that nurses stance on patient 'attendance' is similar to Latour's (1987) description of a 'black box'. Latour describes a 'black box' as an operating premise which gets locked up and is not questioned. What counts in the day-to-day is "the input and output" (p. 3) of the box rather than how the assemblage of elements are organized within. Such assumptions/expectations are taken as fact in the day-to-day which provides "durability and fidelity" (Law, 1986, p. 254). Similarly, Frankenberg (1966) identifies 'black boxes' as being some unknown phenomena which are closed-up and not examined. He claims that such approaches to taken-for-granted operations are "inadequate" and calls for a 'opening of lids' in order to examine what lies within (p. 295). In the context of the day-to-day, 'black box' issues enable nurses to recursively conduct themselves and maintain an 'unpreoccupied' interest in what they are operating their daily practice on. By extension, the implications of such 'theoretical premises' are also not questioned. Nurses' concern that patients attend activities (ie. patients who attend activities are permitted to stay on this ward), reveals an important operating premise which nurses do not question and one which constitutes a condition of therapy. Nurses link therapy with patient attendance.

Another example which supports the view that patient attendance at activities is important to nurses' work arises during nurses' kardex. At kardex nurses regularly go through the 'registry' of patients and identify who attended the scheduled morning community activity. Typically, some indication is also provided about the nature of each patient's involvement during such activities. Nurses use occasions with one another to depict patients' actions during previously scheduled community activities. The following example includes

the strip of interaction from kardex pertaining to a community activity, "baking", as nurse Jennifer calls out patient Janet's name:

> Jennifer: Janet Riley.
>
> Tina: She was up this morning and down to baking and I don't know how she did down there?
>
> Jennifer: She's alright. She was helpful enough. She sort of ... sort of took over and decided to lead the group.

This excerpt is consistent with nurses' emphasis on the centrality of community in that, community activities are discussed in reference to Janet during the first turn of conversation. Janet was "up" and attended the scheduled community activity which marks her as present. Nurse Tina states "I don't know how she did down there" which indicates that she might be expected by other nurses in attendance to know something about Janet's performance. Tina is Janet's assigned nurse for this particular day.

Instead, another nurse, Jennifer, offers her comments on Janet as Jennifer asserts knowing about Janet during this particular activity. Jennifer states "she was helpful enough" as though being "helpful" is important for nurses to know. The nurses' conversation establishes that Janet is one of a group of patients, who was cooperative during this activity. Jennifer's next comment is related to the nature of Janet's involvement during "baking": "she sort of ... sort of took over and decided to lead the group".

I suggest Jennifer's account acts as an alert for other nurses. In this sense, Jennifer's opinion contrasts perhaps with everyday understandings of community, in that, the notion of a person 'leading' would not be uncommon or unexpected action (Cohen, 1985; Frankenberg, 1969; Brownell, 1950; Fernandez, 1986). Everyday images of community embody the notion that some members "lead" during occasions when more than one member is present. In addition, such action may be viewed as necessary and a skill which is promoted by members of a community. In the above excerpt, however, the notion of a 'leader' prevailing, as a 'norm' can be read as signaling a danger for attending nurses. The physical presence of Janet is noted as an appropriate action by her, but that "she sort of sort of took over" also signals the potential danger ofsuch behaviour of this patient for other nurses.

In the above short excerpt, nurses have produced an 'understanding' about Janet, they have come to 'know' Janet in their discourse about her. I suggest such examples demonstrate that community is a structure-in-use governing (dominating and legitimating) the expectation that patients attend activities. Nurses talk up community as an important aspect of day-to-day practice. Nurses use this particular structuring device to direct patients and discuss patients' behaviours with other nurses. Attendance and non-attendance are surveillance activities for nurses which enable them to observe and evaluate patient behaviour.

In another account to me, nurse Jennifer says, that patients "have to at least play along with the rules" set out by nurses. This is supported by cross-checking interviews I conducted with patients. For example, patients' comments include the following: Rory states he 'goes along' with what nurses want when he says "I just more or less do what I'm told"; patient Ginger says "you kind of go along with the flow"; and patient Sasha states that she "was told about the regulations". These examples suggest that the importance of attending activities is supported by a range of accounts from nurses and also picked-up by patients in day-to-day practice. Reflecting upon the importance of, and how 'movement' occurs, here, patients pick-up not merely the importance of attending, but also the account itself. Such accounts consist of governing features of the ward. That is, in using the account patients also implicate themselves into the order of ward activities. What emerges is that the nurses' perceptions are that attendance and treatment are one and the same. This is made explicit by Jennifer in the following excerpt:

> Jennifer: Well we don't really force patients to do anything but we do try and encourage them to attend programmes ...
>
> Maxine: And how do you encourage them?
>
> Jennifer: Uhm, we initially explain what it's for, and that we'd like, I always say "I would like you to attend. I think it would be helpful as part of your treatment." And that quite often will get patients to come even though they're a bit frightened or reluctant. And we can go right to the other end and say "If you want to stay here in hospital you are expected to do these things or you'll be discharged" like we get someone who's here because they're out of money and they're just using the hospital as a hotel and we sort of ... become a little stricter with them saying "If

you want to be here then you have to at least play along with the rules. You can't just come here and watch TV" kind of thing.

Just prior to this excerpt Jennifer indicates that there is not much leeway for patients in terms of whether or not patients attend community activities. Here she says that patients may be approached with "I would like you to attend" and patients are expected to "at least play along". Jennifer qualifies a sense of mere 'playing along' however, by suggesting that it is important that patients show that they are working and not simply being idle. In this way nurses make explicit that patients are expected to perform community. Above, this is expressed when Jennifer states "you can't just come here and watch TV kind of thing". However, I suggest that an 'oddity' arises in that patient's don't really have to be sincere in their performances, they just have to 'play along'.

The above excerpt also stresses Jennifer's view that nurses look out for 'legitimate' and 'illegitimate' patients. This is brought out when Jennifer distinguishes some patients as those who are "just using the hospital as a hotel". The question of 'Why nurses work with patients who are using the hospital for 'illegitimate' reasons?' arises. Following along from this, why do nurses mobilize patients to 'play along with the rules' if they are illegitimate patients?

Nurse, doctor and administrative accounts indicate that nurses do not determine which patients are admitted to this ward. Instead the authority to admit patients is the domain of doctors. This suggests that nurses day-to-day activities may be constrained by particular patients whose doctors admit them as 'formalized patients'. Some patients who are admitted may be deemed by nurses to be 'legitimate' patients while others may be 'illegitimate' patients. Once patients are admitted, nurses work with them. Hence nurses must handle patients who they deem may be 'legitimate' or 'illegitimate'; this may both constrain and enhance day-to-day practice for nurses.

The 'pressure' which nurse Jennifer openly talks about in the previous excerpt suggests that nurses rely on patient's feeling compelled/desire to attend, as it becomes a condition of their acceptance as legitimate patients: "it is an expectation". Largely nurses are not reflective about what is being gained by patients attending community activities. I suggest that this oversight of nurses is important to the continuation of day-to-day practice 'as it is'. Such an

unreflective view of practice (a 'black box') may also account for why Jennifer objects to patient Janet "sort of taking over" during one community activity. In other words, an absence of reflection conflicts with the active sense of "choice" which is what nurses espouse during community meetings presented earlier. Now I would like to explore further accounts including a face-to-face session between nurses and patients which reveal how this taken-for-granted practice occurs and what is accomplished.

Sanctions are in place

Another nurse expresses scheduling of activities (organization) in terms of "it is an expectation" which as noted, reflects the view held by nurses on this ward. That consequences for these expectations are also in place, emerges the following interview with nurse Zana:

> Zana: Sometimes they'll go to programme, and sometimes they won't. And then after that it's up to the doctor to either allow them to not go or discharge them. And usually what happens then is if we have someone who we have in that situation, all the staff will start taking the same approach with that person, applying a bit of pressure to say "We want you to go and do that". And usually after a number of days they will start doing it just because there are that many people insisting that they go.

This example draws attention to how nurses use collective pressure to 'coerce' patients. Zana identifies her knowledgeability of "pressure" and the effect that such pressure has on patients cooperating with the "rules". This nurse claims that patients are openly enlisted into activities but, I suggest that this form of enlisting is more like conscription. Zana suggests that this strategy is utilized by herself and other nurses when she says "we" and "the staff will start taking the same approach". The bottom line is, that, if a patient does not attend, doctors either allow patients to not attend or patients are discharged from Bestcare. Sanctions are in place to produce and reproduce attendance which enhances the stability of community practices on this ward.

As discussed, different kinds of encouragement are employed by nurses to get patients to 'go along' with that which is being asked of them: attendance at community activities. Nurse Alison recalls her interaction with one patient when she claims to have said, "ah, we want to see you out there." A firm stance on attendance is taken by and supported by nurses' approaches to patients in

this ward. Through the social forms of coercion, this begins to reveal how understandings of community can not simply be identified as a collective of voluntary subjects. Ethnographic material reveals that this strategy for obtaining patient attendance is an approach which is shared among nurses and one which enables their practice. Nurses do not attempt to conceal their use of 'coercion' on patients. Such an approach portrays how nurses sometimes constitute patients as 'something less than persons' (Latimer, 1993). The 'legitimating' function of classifying groups of people in this way has been addressed in some depth by Bauman (1989; 1990; 1991). In this psychiatric ward, coercion is legitimated through its links with identity as a psychiatric patient. Other authors (Bloor and McIntosh, 1990; Goffman, 1961; Foucault, 1967; Barham and Hayward, 1991; May and Kelly, 1982; and Kelly and May 1982) indicate that psychiatric patients are constituted, as a lower class of people, this categorization appears to legitimate others' approaches to them. Similarly, in a study done in an Emergency room, Jeffery (1979) suggests that chronic, suicidal and alcoholic patients are constituted as 'normal rubbish'. My ethnography, also suggests that nurses' coercive approach can be explained by their viewing patients as different or a lower class of people: coercion is accepted-as-legitimate.

"Community meeting"

Nurses' day-to-day conduct, including a reliance on scheduled activities and on nurse-centred practice, has an effect of minimizing face-to-face interaction between nurses and patients. Face-to-face interaction between nurses and patients is rare in this site. Instead, nurses schedule patient days with activities and importantly, sequester patients' interaction with one another. Whether during activities or outside of activities nurses produce a social distance between themselves and patients. However, community meetings represents one of these rare moments of face-to-face contact. This regularly scheduled activity is now explored further.

"Community meeting" occurs weekly and both nurses and patients attend. Two nurses are assigned to attend this session while the number of patients varies from week to week. The following excerpt is taken from the beginning of one community meeting and is the same excerpt presented earlier

in this chapter. Nurse Leona chairs this session sitting at one end of a rectangular table and a second nurse Martha sits at the other end of the table. Five patients are sitting along one side of this long table and four patients on the other. Patients are currently looking towards Leona as she speaks:

> Leona: policy or treatment, or tell you a little bit [audio tape cuts in and out] a little about in-patient psychiatry so you have a little better understanding. Monday's you come to Community meeting and after this we go downstairs and learn some relaxation techniques ... and I told Sasha [a patient on the ward] I always fall asleep so it is her job to keep me awake (laughs) and on Tuesdays we do crafts together ... and on Wednesdays is an outing and its your choice. Sometimes they go to the park, sometimes bowling, last week they went to the parade, its your choice. And these are all important things like don't think "Crafts, big deal?" They are important things because they give you an idea of how you're interacting with other people they give you an idea of how you're doing in the community... its very safe and secure here on the ward and it gives you a good idea to see how your functioning, how your feeling being around other people doing things. So it is important ... And then on Thursday we do baking and you choose what you're going to bake. Usually with baking there is time to do some games and things too.

Leona is setting out her aim to "tell" patients about "in-patient psychiatry" so that patients "have a little better understanding" and also to "give you [patients] an idea of how your doing in the community". However, Leona links the notion of understanding with patients being told, which is what she is currently doing with these patients. This suggests, in Leona's view, understanding is a straightforward process; a matter of being 'told'. According to such a view, nurses are accomplishing their part by 'telling patients' what to do. In contrast, Gadamer (1989) makes explicit how 'understandings' are not pre-given, but are processual, and take their expression in the inter-subjective moments of talk as individual's ascribe meaning to language (during their "communion" with one another; p. 379). Hence the above version of how patients and nurses come to understand one another is problematic. Nevertheless, Leona conveys conditions surrounding the weekly schedule for patients as she goes on to identify one activity for each of the weekdays. These conditions mark a view of understanding which Leona appears to be suggesting; in this community there are rules to be followed. Here, patients are being provided with instructions and rules.

I suggest that Leona presupposes that community holds some value for patients. In particular, its value is pointed to in brief statements such as the *value* of community as a "safe and secure" environment. This statement suggests that the value is 'self-evident'. For instance Leona tells the group: "(s)o it is important". A self-evident quality is presented in a circular manner as Leona works at 'convincing' the patients of some inherent value. She suggests the activities are an important part of community and community is important because, in it, you can act out, and test out your behaviours during the planned activities. This excerpt reveals Leona claiming the importance of, and appealing to an image of community among patients. Leona's expressed view appears to reflect that patients have an opportunity to get 'more'/value from having particular types of relations with others. She accomplishes this by asserting a play of different aspects of community to constitute a view of community for these patients.

During interaction which follows at this community meeting, patients in attendance do not contest the purported significance of community. This 'going along' suggests that community as language-in-use has an effect on patients. Not only do patients not contest this version of practice, they demonstrate their knowledgeability of the image as a 'structure'. Another way of phrasing this is that notions of "community" are offered by nurses as essential elements toward healing. As such it appears that patients accept community as something that is commensurate with their understandings.

The imperative to accept the implied priority of an image of community is signalled through Leona's portrayal of her commitment to community as she emphasizes its "importan(ce)" three times in this excerpt. Leona then moves on to identify the schedule for patient activities in this particular week. In this way she identifies an important notion of community and goes on to produce an illustration of how community will be produced in this setting. Leona accentuates the importance of community by the 'added' emphasis of the activities which she is about to schedule. Despite the absence of substantive information in Leona's performance, patients do not object.

In the above brief excerpt an image of community in practice has been charted and some tangible activities have been attached to the notion for

patients. This acts to underline community as significant for patients: Leona has done some work to make community meaningful for patients. At this point, whether or not the meaning she identifies is effective for each patient is not an issue. This fairly short excerpt illustrates Leona accomplishing the language, announcing community as a priority of day-to-day affairs, and in so doing, she also demonstrates her competence to 'do nurse'.

Also incorporated in Leona's performance pertaining to her view of community are matters of a moral nature. Leona suggests that community activities such as "community meeting", "relaxation techniques", "crafts" and "an outing" are 'good for you' because "it gives you a good idea to see how you're functioning, how you're feeling being around other people". She makes explicit that the value of community is something these patients will benefit from. This implies that the activities themselves are therapeutic. For instance, 'therapy' is suggested as being inherent in scheduled activities of "community meeting", "relaxation techniques", "crafts", and "an outing" .

Leona connects community with the activities which nurses are making available for patients in this ward. In this respect, Leona is providing both direction and a modality for patients to heal. This directing plays on patients' frames of community and with the importance of activities that 'go on' within ward boundaries. These associations suggest that 'all that patients have to do' is to get involved with the activities which Leona identifies and they will be enabled to move towards a state of wellness. This also makes Leona's view of patient healing explicit. If patients want to heal then all that is required is 'merely' for patients to choose to attend community activities.

Such a choice by patients also underlines a translation which is being sign-posted by Leona. She is suggesting that community can be translated into practice through patient attendance at the organized activities. Here nurses' interests (identified by Leona), in establishing a functioning group (a community) with scheduled activities entails work to translate nurses interests into those appropriate for patients. This precise process of translation is discussed by Callon (1986). Callon identifies the process of translation as one which gets the desired interests of one group across to others by way of translation. In the hospital ward, a patient has no other place to go for healing.

In the above meeting Leona makes efforts to get across the self-evident value of community as an interest that patients would represent as their own. This example also resonates with Munro and Kernan (1993), following Latour's (1987) view, to make control "invisible" (p. 2). In particular, I suggest the discourse "choice" renders control invisible, as well as, the act of 'choosing' represents a discursive practice.

Leona makes an effort to enlist patients' interest in attendance at these scheduled activities. She talks about 'choice' with the spoken words "you choose". This evokes a sense of desire to be involved in determining the outcome of, in this case, "Wednesday's outing". By projecting a sense of choice onto these patients Leona transforms what is a passive acceptance of the only 'therapy' on offer into an active state of taking-up a particular therapy modality. Such instructions from nurses in this activity reveal that patients are expected to 'be active', attend and partake in organized activities within this community in the name of 'therapy'. This represents a crucial transformation that patients are 'required' to take heed of; therapy can only happen if patient's 'do' the activities suggested by nurses. In this way, patient involvement in community is constituted by nurses at its most basic level by a patient's physical presence. Importantly, as has been discussed, most patients do attend community sessions.

I have focused on what nurses do to accomplish day-to-day stability as they draw from community. Nurses make explicit that there are rules which patients are expected to uphold and that attendance at community activities is paramount. Hence, a first work space is created for community when patients and nurses have face-to-face interaction. Now I would like to turn to focus on what patients appear to make of community in day-to-day practice. During the next section I aim to mark out some of the apparent similarities and differences between nurse and patient understandings as community is performed socially.

Alternate ways of reproducing community: individual transformations

The term "community" is also used by patients in this setting, indicating that patients share the same expression as nurses. As discussed by Cohen (1985) it is important to note that I am not suggesting uniformity of meanings attached

to "community" as a shared expression (p. 70). Patients hear nurses making reference to "community" and patients sometimes make reference to "community" themselves. A similar effect was noted in relation to one-to-ones which is the way nurses refer to face-to-face interaction with patients. After some time on the ward, patients to alter their speech and employ this term (for an example, see p. 79).

However, an examination of patients' language reveals that the specific term "community" is infrequently spoken compared to nurses. I suggest this reveals that language has had an effect on patients and that there is a rippling effect of the selected language-in-use as patients interpret it for themselves in day-to-day practice. Importantly, nurses leave open the ways in which the term community is to be interpreted by patients: stability is produced by nurses scheduling activities. In this respect then, patients' reproduce aspects of community without necessarily mentioning the term community. Patients provide examples, but of a different version, in the way in which they constitute community inside the geographical boundaries of this ward. I suggest that the alternate ways of reproducing community which patients accomplish are an effect and product of them taking-up community as expressed by nurses. Patients make sense of nurses' expressions for themselves and perform their understandings of community in the day-to-day.

Patients frequently reveal aspects of community in describing their day-to-day activities. I suggest that patient Ginger points to an image of community when she states:

> Ginger: Well, they say ... like we all meet at one big round table and I guess that is very uncommon. My doctor even noticed it. He said "Gee everybody is eating together at the big table, you won't see that very often" and it kind of let me know like, "Hey, even though other people have mental illness, we are still all people, we are still humans" and while we are here, these are all our friends we have and the other one said "Oh come on, we are going to the morning activity now, so. Come on down with us". So that kind of gives you a feeling of belonging to the group and then for group therapy as well. It is on the board for everybody to read and first couple would say, "Come on down we are going down to group therapy, come along with us".

Among other significant details, this excerpt reveals that Ginger is knowledgeable about reproducing a particular image of community. She draws

on other language "we are still all people" suggesting that people 'naturally' form "friend(ships)" and invite one another "along" to activities. Ginger reveals that patients are social with one another. Language such as "come on down with us" embodies inviting and friendly talk among the patients. A particular regard for an image of community is made explicit when she states that such interaction "gives you a feeling of belonging" at the table in a common area of the ward. Ginger also parallels this view to "group or group therapy". In these ways, patient Ginger constitutes aspects of community without identifying the specific term during her talk with me.

Similarly, patient Rory illustrates some understandings of community in day-to-day affairs while discussing pleasurable activities:

> Rory: I ended up having a good time... after you get to know the people. Just by ...they've got the TV room. Can't have TV's in your room, so everybody sits and talks, everybody eats together out there (points to dining area) not like eating in your room. It makes it easier to get to know somebody instead of being cooped up in your room all the time...it is encouraged and it helps too. Like the last time I was here I had a ball.

He suggests that patients "hav(e) a good time" with one another in the TV room. In the TV room patients are geographically and socially distant from nurses. He also suggests that as a result of patients being 'together' and not being "cooped up in your room all the time (...) helps". Rory identifies patients as people which implies that he does not confine his view to that of other patients being ill. He portrays a sense of affiliation with other persons and explicitly states that such associations "help". This echos Cohen's position when he states that people are attached to community as "an empirical phenomenon" (1985, p. 38). Rory's comments underline an experienced sense of closeness and being social among patients in: "after you get to know the people". Rory draws attention to an enjoyment that comes from 'belonging' to a community within this ward. As already presented, patient Sasha refers to a sense of affiliation which she has experienced when she states that she will "miss them [patients] after I go" (p. 50).

Patients display a shaping of themselves as 'a member in the community' in this particular setting. In a routine meal time practice (for patients), a cart is brought to the ward and the meal trays are picked up by

patients and taken to a nearby table where they eat in a common area. Patient Ruth stated that she gets her "own tray ... [and] take[s] away her] own tray" (p. 75). In some cases nurses will provide this service for elderly patients or those who are physically unable to transport a meal tray from the cart to a table (see Alison p. 47). Also, younger patients unsolicited by nurses assist older patients with the movement of the meal tray to a table and return the empty meal tray to the cart. These performances reflect everyday understandings of community as taken-up by patients in this site.

Such examples provide a reading of patients' understandings about community as evidenced by their assistance to one other at meal time. While the fact that patients eat together in a communal area of the ward is stressed by nurses, and that such cooperation evinces patients cooperating with 'rules', that patients assist one another with the transportation of their trays may exemplify patients' reflective understandings of community. Nurses do not appear to instruct patients directly to assist with older patients trays (although patients' may see nurses conduct this activity), patients act on their own accord. I suggest that this is one way these patients transfer their everyday 'understandings' of community to the present situation in hospital (refer to p. 13). Such a view resonates with Munro's discussion (in press) of kinship ties which emerge as important to management ethos in a successful business (Bestsafe) in the financial sector.

Munro discusses how kinship relations emerge from members' practices within a formal hierarchical organization. In this organization 'access' to senior staff (and resources) figure prominently in day-to-day relations. Such access implicates future productivity or delivery for the company. Everyday affairs were notably handled during organizational talk across functional hierarchical levels while planned strategies were negligible. The kinship relations which members develop with one another "saves Bestsafe" from failure (p. 53). Munro addresses social bonding and kin:

> The process of social bonding arises not so much because of an inherent property of a hierarchical relationship, such as power or comfort. Rather over 'access', managers invest meanings in its apparent opening and attenuation *and*, in the context of delivery being ambiguous, seek to check their stories with each other. Against theories which might instantiate trust or kin as a necessary

> or sufficient criterion for 'social bonding', Bestsafe illustrates how a (socially constructed) artefact, such as 'access', may recursively constitute a condition of possibility for the social construction of kin (p. 49).

Social bonding among members is displayed by checking "their stories with each other". Munro also states that "layers of loyalties" can be likened to an 'extended family' and a sense of "belonging" can be likened to a 'tribe' and that these are critical for day-to-day operating (p. 25). He goes on to suggest that kinship is a 'local' matter while descent in terms of authority is a 'company' matter. In relation to aspects of community, Munro's ethnography shows how kinship emerges as central to organizational work practices. 'Access', in its possible attenuation, contributes to the possibility of kinship relations. He draws attention to the social accomplishment of organizing practice as kinship ties are not instantiated by way of conventional means, nor are they divorced from the hierarchy like authors such as Ouchi (1979) suggest. Members of Bestsafe like patients on the ward draw from aspects of community in their day-to-day practice.

Unsolicited displays of community by patients are actions that nurses notice about patients and report to one another during their discussions in "kardex". As is discussed in detail in Chapter 7 kardex is a routine occasion when nurses exchange information about patients (in day-to-day practice, nurses' use *kardex* as both a verb and a noun). In one instance nurse Iris remarks to other nurses that patient Crystal "taught a bunch of the other patients how to play a game and ah they really enjoyed it". Another example of nurses reporting such community performances of patients to other nurses occurs with patient Crystal:

> Nora: Crystal was doing her hair and stuff.
>
> Leona: yeah, she's doing everybodys' hair.

That Crystal is "doing everybodys' hair" is worthy of recounting at report and is used by nurses to signify something about patients. Here is an instance of a communal activity which is initiated by patients and, this also marks one which is permitted and endorsed by nurses. Thus, patient Crystal has been observed and is perceived by nurses to be 'helpful' ('doing community') with other patients. Here, I suggest there is a shared meaning between a nurse-centred

image of community and Crystal's patient-centred view of 'doing community'. Crystal reveals a transfer of an understanding about community in the public domain of this ward. Such a display conveys this patient 'taking-up' community. This is important to note because, as will be shown in Chapter 5, nurses and patients do not always agree on acceptable community performances.

Patient Ruth represents another patient who expresses understandings of aspects of community. In this instance, Ruth responds to my question "what do you think is expected of you?" during an interview account with me:

> Ruth: Well, not any more than the rest of them. Keep your room tidy, if you make something make sure the mess is cleaned up and the dishes are done and if you smoke and that, empty the ashtrays and take your own tray back to the wagon and get your own tray. Go up and get your own medication.

This example reflects Ruth's familiarity with the rules which she happily performs. However, I suggest this example conveys a different tone and one which depicts her conforming with particular rules of the ward. Ruth's example contrasts with previous patient examples where a display or account of aspects of community were delineated. Ruth promptly identifies distinguishable 'work activities' as expectations of her as a patient in this geographical location. These work activities "keep your room tidy (...) mess cleaned up and (...) dishes . . . done", provide instances of concrete activities of her daily conduct. Similar concrete work activities which express aspects of community were identified by patient Sasha (pp. 49-50) in: "do your own laundry, ironing, keep [her] room clean". Also in Sasha's case, with some consideration, she suggests that these sorts of work activities seemed reasonable: "Oh my gosh. Then I thought it was a good idea, you've got to do something". Sasha also indicates that she had confirmation of her view with her sister's visit who Sasha reports to have said "(m)y sister was up and she thought it was good, you know, it keeps your mind of other things". Patients reproduce aspects of community in their daily practice which appear to be commensurate with everyday understandings of community.

It is important to recognize that any helping does not necessarily count as a community performance which I suggest, resonates with Munro's (in press)

discussion of kinship. His discussions reveal a careful use of kinship where not every relationship reveals a sense of kinship. Similarly, in this ward, a particular patient helping is just helping. However on specific occasions, such as those noted above patients have been told that certain occasions of help is community.

This contrasts with Bloor and McIntosh's study where views of therapeutic community are imposed on all activities. They make explicit how there is an imperative to 'redefine and invest or impute new meaning' into behaviours of patients by nurses and doctors. I suggest that the following quotation marks the intensity in practice, which members of a therapeutic community setting employ to *manage* what can be couched in therapeutic terms:

> community work can be conceived of as an act of cognition which transforms any mundane event in the social life of the community by redefining that event by reference to some therapeutic paradigm. (...) A simple act like cleaning the toilets or mending a leaking tap is invested with new meaning and held up as relevant to the cleaner's recovery or rehabilitation. Any and every event and activity in the therapeutic community is potentially open to such redefinitions; there is no nook or cranny or resident life that is not open to scrutiny and potentially redefinable in therapeutic terms (p. 164; also Bloor, et. al., 1988, p. 5).

Here, Bloor and McIntosh describe community as a therapeutic device through which seemingly all action is interpreted and 'measured'. This overlaps with Rapoport's (1960) discussion where he suggests that "every aspect of hospital life is regarded as relevant and potentially therapeutic" (p. 270). Implications of such actions would appear to resonate with Foucault's (1973; 1977) view, in the above case, that community is disciplined and is disciplining in all day-to-day conduct. In this way, modelling community as a therapeutic device, conflicts with the position I have put forth to this point in the discussion where interpretation by members (Cohen, 1985; Gadamer, 1989; Wright, 1994) is important. Bloor and McIntosh note that as a therapeutic device patients' views are displaced in favour of what providers constitute as proper definitions and measurements of acceptable community behaviour.

In a similar way, my view also corresponds to Tilley's (1990) findings in psychiatric wards. He shows, using accounts, how nurses work at negotiating

patient experiences and meanings. Nurses translate and exclude patients' meanings on the basis of nurses' discourse (knowledge/power): "the objectivity of patients' subjective reality had to be negotiated" (p. 165). In Tilley's study what 'counts' as meanings are based on the nurses' frames of meanings.

In the current study when nurses talk up occasions of help to stand for community, such occasions stand for community. Importantly, I am not saying the above discussed occasions of help are community. Instead, nurses are saying these occasions act as community rather than others. Further, crucial occasions have precedent that are talked about by nurses.

Collectively, the above examples arising from patient accounts suggest that there are different ways of reproducing community. Moreover, the specific term community does not have to be used to 'get across' aspects of community performances. Some aspects of community arising from patient accounts have included the following: perceptions of belonging; enjoyment and fun; getting to know people; being located in the same territory or being together; affiliating with other patients; and individual expectations or concrete work activities in a defined area. In these ways, I suggest that patients show that they are 'knowledgeable' of, different aspects of community in their day-to-day interaction. It is safe to say that patient understandings of community are apparent and translated to their current experience in this ward. They reproduce community without uttering the key term community in the ways that the nurses do. Following Cohen (1985) and Gadamer's (1975/1989) perspectives' persons-as-patients prior experiences cannot be sealed outside hospital doors.

In the absence of explicit direction from nurses, alternative understandings demonstrated by patients suggest that patients probably have an image of community prior to being admitted to this ward. It is however, impossible to separate these previous understandings from what they have picked-up on as the preferred image of the ward. Prior images with which patients arrive must effect their conception of, and expressions concerning community. This leads to the question: 'What enables patients to reproduce desired aspects of community inside this setting?'

As discussed, there is an instructional component of nurses work with patients in that nurses provide patients with instructions about how to 'do community' inside the ward. The particular types of instructions that patients receive vary. For example in revisiting the example of community meeting (pp. 54 and 67) nurse Leona provides patients with "important" activities which are not to be minimized when she says "like don't think (c)rafts, big deal". In this case patients are being instructed on how to value their involvement. She goes on to further elaborate on instructional components for patients when she says "how you're interacting with other people they [activities] give you an idea of how you're doing in the community" which exemplifies for patients how community is to be accomplished/done in this ward.

Instructions from nurses elucidate rules and they act to 'boost' patients' repertoire of performances for community while signalling other aspects of day-to-day affairs. There are three distinguishable modes, from which patients draw, to act out community in this ward. Firstly, nurses mark out community by tapping into prior understandings of this image. Secondly, nurses provide instructions for patients about conducting themselves in community activities. Thirdly, patients draw from other patients in their renditions of community.

What emerges from ethnographic material is that a second work space for community performances is created. In particular, within the day-to-day patients are left to 'do community', in that for large periods of time they are left without supervision. However, rather than specifically instructing patients in this regard, nurses leave open specific ways in which community can be interpreted and, during these periods of time, patients engage with each other in ways which appear to reflect everyday understandings of community as much as they resonate with discourse effects from nurse-patient interaction. In this sense, community is brought into being in ways that help to produce and reproduce modes of participation in day-to-day work. Here, I suggest participation invokes community. Although seldom described as such (participation invoking some notion of community) in existing literature, it is interesting that participation seems to have become detached from the notion of community. Pausing and extending this view, it is impossible to think of community without invoking the notion of participation. However, it is

important to use some discretion and not assume that all participation is community and vice versa. This is remarkable especially given the above discussed views of Bloor and McIntosh (1990).

That patients produce aspects of community acts to further facilitate community and legitimate nurses use of an image of community. This is now discussed.

Patient performances legitimate nurses' use of community

Nurses state overtly that involvement in community activities is the wayin which patients accomplish healing. Nurses legitimate their scheduling of patients day-to-day activities by drawing on an image of community and connecting this to healing. Patients pick-up on this and reproduce the legitimacy of community in day-to-day activities on the ward for themselves and other patients. This relates back to the infrequency of face-to-face contacts between nurses and patients. The rarity of face-to-face contacts with nurses suggests that community activities are that much more important. For example, Ginger suggests that nurses "really encourage" patients to attend activities. I asked Ginger how nurses "really encourage" patients. Her response is:

> Ginger: Well, I did not have a problem with it when I came but I notice with some of the other patients and I have kind of watched how they have dealt with them and they might ask them, "Well what it is that is bothering with them, bothering them, that they don't want to partake of a certain thing". Sometime, it can't be said right at the time, so that they should just talk to the nurses on a one-to-one afterwards and explain to the nurse and so then the nurse has at least some insight as to what the problem was and whether that activity would make even make it worse unlike me. It would also be like: "This is part of the treatment plan"; "We really encourage you to go to an activity"; or "Everyone partakes of this activity, we would like you to partake of it too", that kind of encouragement. I suppose if the patient just flatly refuses for his or her own sake, the nurses can only do so much too. If you don't want help yourself, you are not going to get it. (...) That is all part of our therapy program and if you are going to be in Rome, you can only do what the Romans do.

Here, Ginger legitimates nurses' handling of the patients day-to-day activities, identified above as: "our therapy program"; being in Rome and following such a "program" as the offered means to healing. Another way of phrasing this is in reference to particular geographical and spatial contingencies. When patients

find themselves in a location where a well established organizing structure is set out there is a choice to conform or rebel. For Ginger the 'obvious' choice is to conform.

According to Ginger, this is simply put, if a patient gets involved, this counts for wanting to be helped. This suggests that patients are put in a position where they express feelings of being compelled to become 'members of the community'. Nurses watch for evidence (verbal and behavioural) of patients acting out community. If observed, nurses treat this as though patients "get it". Patient Ginger raises the notion that through one-to-ones nurses find out how to help patients. In this way, encouragement to attend group activities is constructed as something which is 'planned' and, if followed, patients will have an opportunity to heal. Similarly, if patients resist, their chances for healing are implied as less likely. As with nurse Jennifer, patient Ginger places an emphasis on patients' attending in "this is part of the treatment plan" and such a 'treatment program' is not questioned. Ginger states:

> Ginger: Your program in the morning is part of the treatment because it does get you doing something whether you like it or whether you don't like it, you are encouraged to do it anyway. And you are really encouraged. Like they kind of frown on you, if you don't partake of that. It is for your own worthwhile because you are mixing with other people, some of them are in their depression, maybe greater or smaller than what you are going through, but talking to other people knowing that you are not the only one that has been sick, that is different degrees of this kind of illness. That was something that I think I was kind of reluctant of before I came in because I thought: "Gee I am not schizo, what am I going to find on this floor? Am I going to be half healthy and half sick". And I was a little bit nervous about it, but after coming here and the environment and everything, it is good.

Ginger suggests that sanctions are in place and that "whether you like it or whether you don't like it, you are encouraged to do it anyway". Second, "(i)f you don't want help..(...) you are not going to get it" resonates with how nurses legitimate their use of community to get patients involved. Involvement of patients can be identified in a number of ways. For instance, nurses claim that "structuring patients time and giving them something to do" is what nurses work towards (they "encourage"). Above Ginger claims that "they kind of frown on you if you don't partake" and "talking to other people" are modes of bringing community as a structure into being. Nurses identify the "structure"

that organized daily activities provide for patients. This is close to the perspective taken by Giddens (1984) in his use of the term 'structures' (p. xxxi and p. 377). Ginger's view of nurses' references to "structure" above portrays a sense of ordering through 'schedules'. In turn, this term reflects the essence of what nurses' references to "structure" convey. Giddens perspective is that people bring structures into being: structures do not exist by themselves.

Treating patients the same

Importantly, nurses are knowledgeable about and observe patients' interaction with one another. However, they appear to separate off community which they espouse from the actions of patients in performing community. That nurses treat community as something which is unambiguous also arises from their view that all patients are handled the same without special privileges. Nurses appear to explain such practice in terms of 'fairness' as though I (and others) would suggest that patients ought not to be treated in ways which reflect their personal identities. This is the view that nurse Zana describes to me in the following passage:

> Zana: you know they all receive, if I've got the time they all receive the same amount of time as far as talking with them, even if they have been in the hospital for awhile, all patients [are] treated the same definitely.

The way in which all patients are conceived of and handled 'the same' by nurses (with the caveat above "if I've got the time") also arises from one nurse's account (Jody) when she puts this in terms of "the same rules apply." In another case, Naomi emphasizes the view that patients should be 'treated the same' during a ward meeting with nurses:

> Naomi: And that's what I say when I talk about, "I don't care if we are all going in the wrong direction, but, I want to all go in the same direction at once." Cause, if we don't, we just undermine each other and confuse the patient.

Organization and stability are important to Naomi. In relation to day-to-day practice she stresses that nurses organize and collectively enact activities which she presupposes are agreed upon by nurses in this ward. She appears to suggest that a concern for individuality in the day-to-day treatment of patients would

undermine the unity of a collective group of nurses working 'in the same direction'. In describing features of total institutions Goffman (1961) states:

> First, all aspects of life are conducted in the same place and under the same single authority. Second, each phase of the member's daily activity is carried on in the immediate company of a large batch of others, all of whom are treated alike and required to do the same thing together. Third, all phases of the day's activities are tightly scheduled, with one activity leading at a prearranged time into the next, the whole sequence of activities being imposed from above by a system of explicit formal rulings and a body of officials. Finally, the various enforced activities are brought together into a single rational plan purportedly designed to fulfil the official aims of the institution (p. 17).

As already noted, and contrasting with, Goffman's finding, on the psychiatric ward not all aspects of patient days are "tightly scheduled". Yet similar to Goffman, day-to-day practice effects a sense of economy by way of patients attending the same activity thereby minimizing the work for nurses.

A 'group' approach to patients facilitates nurses work with a number of patients at the same time. This is the precise way in which Munro (1993) builds on Goffman's (1961) work to delineate "action in a block" (Munro, 1993, p. 14). Goffman states:

> When persons are moved in blocks, they can be supervised by personnel whose chief activity is not guidance or periodic inspection (as in many employer-employee relations) but rather surveillance - a seeing to it that everyone does what he has been clearly told is required of him, under conditions where one person's infraction is likely to stand out in relief against the visible, constantly examined compliance of the others. Which comes first, the large blocks of managed people, or the small supervisory staff, is not here at issue; the point is that each is made for the other (Goffman, 1961, p. 18).

Munro suggests that Goffman is pointing to "action in a block". This occurs, he suggests as a result of the violation of one person who "stand(s) out" and becomes "visible". By 'standing out of order' the practice of surveillance is facilitated on the members. As Munro indicates, such practices draw attention to the "*creation* of social distance" (p. 14).

In this ward, for nurses it is economical to schedule patients time to permit 'action in a block' as opposed to working with individual patient's. Within such practices there is a sense in which an economy of effort is possible and enables those managing patients in particular spatial and geographical

areas. This type of economy of effort arises from Goffman's view of the organization of "the large blocks of managed people" surveyed by "the small supervisory staff" (1961, p. 18). I suggest that Munro's view of 'action in a block' is enacted by nurses as an economic strategy, distancing patients both socially and geographically from nurses, and at the same time to 'do community' legitimates this strategy.

Emerging image of community

As previously noted, I have shown that nurses leave open the ways in which community is to be interpreted by patients (see p. 71). This helps to explain differences between nurses and patients in relation to the frequency of "community" as a spoken term. As already noted, I have suggested that the alternate ways of reproducing community which patients accomplish are an effect and product of them taking-up "community" as expressed by nurses. The significance of nurses' approach, in getting across notions of community to patients, is sharply contrasted in literature concerned with a view of therapeutic community. Above I have already pointed to Bloor and McIntosh's (1990) study. In order to further illustrate the contrast of "community" as an emerging notion which patterns day-to-day practice, rather than one where practice is prescribed, I depart from the empirical material constituting the current study to emphasize this important difference. Literature concerned with readings of practice as a therapeutic community impose particular notions of community rather than allowing for each persons' interpretations to figure in the day-to-day.

For example, notions of therapeutic community resonate with managerialism. The therapeutic community model is a mode of delivering care to psychiatric patients aimed at managing day-to-day behaviours of patients in self-contained locations (Prior, 1993; Bloor, et. al., 1988). An emphasis on a managerialist approach arises where the delivery of psychiatric care to patients is prescribed by plans, routines and expectations. Doctors, nurses and patients are instructed to conduct themselves accordingly. Here, there is a reliance on teaching doctors and nurses, as well as patients, about acceptable performances in contacts with one another. Jones (1982) and Rapoport (1960) identify 'community meeting' and 'ward meeting' as activities for such discussions. By

his own account of "synthesizing" (p. 134) aspects of day-to-day therapeutic community practice, Jones (1982) identifies a ward meeting (between doctors and nurses) as an instance for precisely this kind of activity, "training":

> (...) witnessed by everyone, but viewed differently by each individual according to many variables, including personality, educational background, motivation, etc. To turn this shared experience into a learning situation (training) for the staff, a review supervised by a competent facilitator has enormous potential for social learning (pp. 134-135).

Jones goes on to identify what such forums (ie. ward meetings) of review are used for in the following:

> (...) an attempt to 'relive' the process with the staff immediately following the community meeting [attended by doctors/psychiatrists, nurses and patients] and examine the group process from beginning to end. Did the group start on time? Who sat beside whom? Did staff form clusters? Who spoke first? And so on. Verbal and nonverbal communication are recycled with a view to examining staff performance (p. 135).

That training is important for staff and patients is addressed frequently by Jones (1982, pp. 134-149). An emphasis on training suggests a particular form of knowing on the part of the identified experts (doctors, psychiatrists, nurses) who Jones claims "ha(ve) a degree of objectivity" which others gain skills from (p. 135). I suggest this 'skilled' approach to activities of care in the context of a therapeutic community emphasizes how behaviours are *managed*. Here also, Rapoport (1960) notes that "the therapeutic yield" of such practices "must be optimally managed if effectiveness is to be maximized" (p. 304).

That therapeutic community practices reveal a series of pre-established modes of ordering becomes apparent when exploring more recent research conducted by Bloor and McIntosh (1990, refer to p. 76). As previously noted, they suggest that there is an imperative to 'redefine and invest or impute new meaning' into behaviours of patients by nurses and doctors. As already noted this is at cross purposes with my aim to explicate how meaningful accomplishments of community evolve through interaction of persons on the psychiatric ward examined in this study.

Another important implication of a managerialist conception of models of therapeutic communities are that, researchers and health care providers take-for-granted that providers (managers) of care practices act in helpful ways

towards the recipients of care practices or those who providers claim to serve: patients. In this sense, intention is privileged over the experience of recipients. Also what is privileged are intentions of care practices rather than the products and effects of such an approach to patient healing. In this respect, a focus on intentions (of providers concerning the provision of health care), help to by-pass the inclusion of examining receipt of such care practices. Once this move occurs to discount patients (experiences, meanings, use, healing and so on), they are *forgotten* examination of intended practice is produced and reproduced without consideration for day-to-day practice. It is precisely this kind of *forgotten* feature of day-to-day practice that Cooper and Law (1994) and Law (1994) attempt to safeguard against by emphasizing the principle of symmetry. Similarly, Argyris and Schon draw attention to with distinctions between espoused-theory and day-to-day practice. To achieve such perspectives it is important to obtain observational material and interview accounts of everyday practice for purposes of cross-checking. It is worth emphasizing the importance of examining perspectives from both recipients and providers, so as to not overlook what knowledgeabilities and competencies persons routinely draw from in the day-to-day.

An emphasis on training, such as that noted above in Jones' work, suggests that there is a 'correct' way to 'do community'. This leads to pre-defined means of imposing standards and uniformity of practices on persons constituting that practice. This can be likened to a mechanical sense of community which rests on notions of functionalism. To administer, manage and teach community implies a desired end of uniformity and standardization which invokes a type of stability for those with a view to manage such activities (ie. a technology of control with specific interests in mind). In this sense, 'A' then 'B' then 'C' depicts a managerial device which is precisely what writers such as Cohen (1985) and Bernstein (1989, p. 226) stand against. As previously discussed, my approach is similar to that of Cohen and Bernstein who argue that engineering and administering community ought to be guarded against. Efforts to prescribe community behaviours displace community as an inter-subjective experience where people draw from their horizon of understandings.

Such a stance infers that community can be imposed on practice, rather than community as constituted between members as a social accomplishment.

From a slightly different perspective Wright (1994), addresses differences between literature concerned with anthropology and organization /management. She claims that formal documents such as a mission statement are developed by:

> dividing up each task into tiny details and specifying how each should be done. These are imposed on the workforce through training and disciplined supervision (p. 2).

She goes on to indicate that such approaches effect how researchers subsequently describe day-to-day practice in that, researchers re-present the day-to-day in a managerialist manner. This underlines how researchers contacts with managers, rather than say consumers of services, effect literature which conveys researchers having played "a central role in 'making' organizations" (Wright, 1994, p. 3). Another problematic as Wright notes, is that such accounts accomplish a skewed sense of the day-to-day in attempting to privilege consensus while at the same time suggesting that there is "no ambiguity" (p. 3) in meanings. According to Wright, such a view is an important difference between organizational and anthropological viewpoints. In this way, similar to Cohen (1985), Wright stresses how meanings in day-to-day practice are "actively contested" (1994, p. 4) and that it is important not take-for-granted that meanings are variously interpreted.

It is Wright (1994), who emphasizes, quoting Cunnison, that people bring meanings into the day-to-day work situation and that such meanings are "drawn into the work situation and integrated into the productive process" (p. 14). This notion of day-to-day practice cross-links with Goffman's notion of a semi-permeable membrane. In this view, what is emphasized is that aspects of individuals enter with an individual at a workplace. Although this sounds like a truism and one which may be so obvious that it can be taken-for-granted, it is important to recognize what such a view implies. Wright (1994) draws attention to Emmett, Morgan and Walker's work to problematize how such a view is conceivable. Here, only some "characteristics of all the individuals from all aspects of their lives are treated as relevant" (p. 14) in the workplace. Those characteristics which are drawn into the workplace are transformed in the

process of day-to-day work. Wright goes on to quote Emmett and Morgan who claim that there is a process of selection and transformation in order to "serve purposes peculiar to the workplace and interaction in it" (Wright, 1994, p. 14). I suggest, this reiterates previous discussions of Cohen and Strathern, but here, Wright states that persons "make meaning in a particular situation out of an available cultural repertoire" (p. 14).

It is significant to note that persons bring themselves to the workplace and it is impossible to think of them leaving bits of their person at home while the other bits of the same person are taken into the workplace. This goes to say that, those aspects which are deemed relevant or pertinent for a person, at any moment in time are those which come to bear in their day-to-day activities. What emerges as important in this respect is 'what' and 'how' are significant aspects brought-into-being as well as, what and how are the effects socially accomplished. This underlines the relevance, then, to examine how meaning is socially constructed by persons in the workplace. It also follows, that it is important to explicate different meanings of day-to-day practice as persons impose and make readings hold. Such readings are expected to reveal particular effects.

I now return to discuss community as accomplished in the ward examined for the current thesis.

Community as an organizing structure

The accomplishment of community has been traced to key language in day-to-day practice. An extension of the key term used by patients appears to be an effect of the language used by nurses. A particular form of words are uttered, so they are likely to have an effect in particular ways. Such extensions give rise to transformations, as patient's pick-up on this key term and perform their understandings of community. In this way, it is important to recognize that language is not simply being reduced to the repetition of language. If such a stance were taken it would imply that the central role that language plays is insignificant. It is worth noting Cohen's dictum that learning words do not "tell you what to communicate" but rather "gives you the capacity to communicate with other people" (1985, p. 16). This elucidates an ambiguity

over any meanings to be read into language-in-use such as community. Cohen makes an explicit distinction between 'shared expressions' and 'shared meanings'. There is no one-to-one correspondence between message sent and message received and therefore language-in-use requires problematization. Language does not 'express meaning' but it gives individuals the capacity to 'make meaning' (Cohen, 1985; Strathern, 1990). 'Understandings' take their expression in the inter-subjective moments of talk (Gadamer, 1979) as individuals ascribe meaning to language. This is a social accomplishment.

Patients pick-up on community and translate their understandings of community in their day-to-day interaction which are meaningful to them. As I will show, patients act differently once they take-up the importance of community which they reveal in their language/discourse (ie. Ginger's view of ward prior to and following some time on ward pp. 94, 113, 181). Patients' displays of community contrast with the constrained approaches which nurses depict in their use of community. As shown, patients pick-up on community and display everyday understandings of community with one another. In turn, patients reproduce aspects of community which act to facilitate the scheduling and attendance at activities that nurses enforce. Such actions appear to underline Latour's (1987) view of actor-network theory where it is the combined effects (not only words used during interaction between nurse-patient but practices in each work space) which produce and reproduce, in this site, community practices.

Nurses treat community as something which is unambiguous. I suggest that nurses take-for-granted that the community they work to produce is consistent with that image which patients take-up. As already discussed (pp. 55 and 67-68), Leona projects the importance of community through her expressed links with values, pre-scheduled activities, as well as the significance of therapy and a patient's choice to attend these. However, the enactment of practicing community as constituted (currently patients attending 'community meeting' as a communal activity), has particular effects on patients. The multiple connotations and ways in which nurses use community implies different meanings (ie. Leona and Naomi pp. 54-55). These different connotations emphasize ambiguity even with the use of the 'same' term.

Nurses talk about patients involvement with community activities and patients "socializing" with one another in the common areas of the ward. At some level nurses are knowledgeable that community works with patients or of patients' attachment to one another. However, nurses are not concerned with the implications of their use of community on patients. Nurses' instantiations of community exemplify a functional orientation in that nurses 'tell' patients what is required of patients and patients cooperate. In this respect, nurses are concerned with 'keeping the patients occupied'. Nurses work with patients in groups or as a 'collective entity' thereby enacting attendance as a central issue in their day-to-day practice with patients. Nurses' employment of community conveys what they understand as meaningful towards their socially accomplished practices.

Whether or not nurses are discursively aware that community is an organizing structure, their emphasis on community enables them to 'move' patients about in day-to-day practice. Through nurses' employment of community they are able to connect community with therapy as legitimate. This enables nurses to sequester patients in spatial and geographical locations. The stability of daily activities for patients provides them with a sense that they have a modality through which they can accomplish healing: patients can participate. The ambiguity of "community" as language together with the multiple connotations which nurses employ in this ward further potentiate the elasticity of this particular term. In this respect, patients appear to gain more from community performances than those directly invoked by nurses. Such a view resonates with Strathern's view of prosthetic extensions (refer to p. 16).

Chapter 4

'Activity of care': surveillance

Introduction

In the previous chapter the key term "community" was identified as an organizing structure for nurses' work with patients. I have shown how patients subsequently take-up and act out different aspects of community. However, it is necessary to offset the view presented thus far of community as something that is produced smoothly. This is not always the case; rather sustaining community practice also manifests difficulties between nurses and patients. One of the aims of this chapter is to examine variant actions which nurses deploy to accomplish community. So, although expressions are shared, 'how' nurses and patients produce, reproduce and thereby sustain community as an organizing structure are explored.

For example, one aspect of practices of community which emerge as significant concern membership. This particular aspect overlaps with Cohen (1985; 1987), Goffman (1953; 1961; 1964) and Garfinkel's (1967) discussions of day-to-day practices. In turn, each of these authors suggest that a focus on membership enables an examination of the rules of conduct. Rules of conduct distinguish the members from non-members which underline their respective competencies. For instance, Cohen (1985) claims that Whalsay Islanders of Shetland avoid public assertion of opinion and that this principle of community behaviour is sufficiently "observed in practice that [their] contravention would identify the perpetrator as outsider or as deviant" (p. 16). Here, Cohen signposts the notion of members (insiders) and non-members (outsiders). Similarly Goffman's examination of Dixon, a Shetland community, reveals that there are two groups of members, the gentry and the locals and they all know who they are (Manning, 1992). Goffman (1964) also points to membership status in that individuals may attempt to conceal that they do not

belong by acting in expected ways. He emphasizes the ongoing work of constituting identity as people move from situation to situation. In contrast, to an emphasis on membership, Lennard and Gralnick (1986) gloss over the notion of membership as unproblematic and take-for-granted that all patients admitted to hospital are members of community (for further examples of authors who gloss over the issue of membership refer to Jones, 1952; Jones, 1982; and Rapoport, 1960).

With a focus on day-to-day rules of conduct of members Garfinkel (1967) also emphasizes the significance of a member's competencies. His investigations focus on members' action in routine day-to-day activities (ie., Garfinkel, pp. 35-75). These displays of competencies reveal whether a member is 'included' or 'excluded'. Garfinkel pays attention to what any member knows about day-to-day activities. He suggests that a member is "capable of managing his everyday affairs without interference" (p. 57). If an individual is not a member then they have no way of being informed about what members recursively know and regularly practice. A member can recognize ("see at a glance") activities which represent life-as-usual whereas a non-member excludes him/herself by not being able to display such actions (p. 54). The concentration on 'inclusion or exclusion' provided by Garfinkel contrasts with Gadamer (1989) whose treatment of individuals implies a view that everyone can have 'membership'. In the current study, I go on to show how membership status is provisional. Similarly Munro (1994) claims that membership is provisional, by which he suggests that the issue of membership is never settled. Importantly, such a view emerges by viewing day-to-day practice as proximal organizings as Cooper and Law (1994) suggest. In particular, a focus on membership as proximal organizings (an outcome of a sociology of becoming) rather than viewing membership as a distal notion (an outcome of a sociology of being or static state) enables my aim to explicate distinctions concerning membership in day-to-day practice. Guided by the above views, I pay attention to the potential for a motility of any distinction between members and non-members as an aspect of community in practice. "We cannot take belonging or social membership for granted: it is a problem which requires explanation" (Cohen, 1994, p. 21).

In the current study, although all patients are tacitly referred to by nurses as being members of community, day-to-day practice suggests different kinds of membership status subsist among patients. As discussed in Chapter 3, nurses stress the way in which all patients are treated alike and claim that no special privileges are granted to individual patients. It is important, nevertheless, not to assume that this is always the case in daily practice (and open the 'black box'). As the following discussion evolves, it will become apparent that some patients are worked on to help them achieve 'membership' status by nurses (patients-as-members), while others are excluded (and as shown in Chapter 3, some patients are aware of this). Such treatment marks a difference in the way that patients are handled by nurses. Indeed, as will be shown, minimal attention is given to patients who fall outside the category of being 'a member of community'. The following investigation reveals how nurses neither invite nor include all patients as a bonafide 'member of community'.

Nurses are not assumed to be solely responsible for whether or not patients attain membership to community. Patients are capable and knowledgeable and their day-to-day performances display their competencies at 'doing patient' or performing community. Patient performances help produce and reproduce particular aspects of community. In turn, these actions effect community performances from one patient to another. This chapter discusses how patients effect their own membership status while being sensitive to the competencies and knowledgeabilities of both nurses and patients. Now I present two salient signals of persons who are viewed by members to belong on the psychiatric ward.

Dress and geographical location

Persons typically located on the psychiatric ward are nurses and patients. Patients know who the nurses are and nurses know who the patients are. In this regard, two formal and important matters are identified by patients as cues during interviews with me: geographical location and attire (dress). Here, both patients and nurses stand out from other patients and nurses at Bestcare based upon the geographical area they are situated in, as well as, their 'civilian dress'. Patients elsewhere in the hospital wear bedroom attire and nurses elsewhere in

the hospital wear uniforms. Similar to other wards, on the psychiatric ward nurses wear name tags and patients wear wrist bands which are visible identity tags.

The geographical location of this in-patient psychiatric ward is well signed by hospital signs indicating "Psychiatry". Also the 'level' that the hospital elevator rises to or stops on; and the attire people are clothed in acts as a strong signal for the destination of both prospective patients and nurses in Bestcare. These signals cue nurses and patients to the psychiatric ward at Bestcare. Once arriving on the ward, the architectural features of the ward stand as distinct from all other wards at Bestcare. The ward is circular in shape with patient rooms around the perimeter. Large glass windows make vision into and out of these rooms possible. This feature resonates with Bentham's panopticon which is analyzed by Foucault (1977; 1980). Central to the ward is an elevated half-moon shaped counter. Further panopticon effect is achieved through a large glass room behind this counter. At Bestcare, the psychiatric ward isthe only one of this shape and architecture.

In terms of would-be-patients, membership has contingencies and the first step in the transformation process for patients is that persons on entering the hospital become immediately transformed into patients by being admitted to the ward (persons-become-patients). This change in identity is integral to interaction which follows as the key element, is that their former identity must be set aside in order to take on a patient identity. One way in which membership is facilitated is by the geographical location of the ward. I suggest that as a result of the psychiatric ward being distinguishable from other hospital wards, that the boundary of the actual ward represents a geographical way of defining membership in the ward.

As noted, the second highly visible distinction of patients and nurses (from patients and nurses on other wards) is their attire or dress. This membership signal has effects on other members of Bestcare. For example, one doctor's remark to me is that the absence of uniforms on nurses (a visible cue) is problematic in: "you never know who are the patients and who are the nurses". In contrast, patient Ginger brings up and discusses dress as a signal for her, during an interview with me, in the following way:

Ginger: In the care and treatment I did not mention that we have to get dressed in our street clothes and I think that is important especially for people that again, are not willing to get out of bed and don't want to get out of bed and figure there is nothing for them. They do have to get out there. There is a shower pretty well in each room, so everything is there for you to take care of your own bodily needs and I think that is important because if you don't feel good as a person within yourself you can't always start to feel good mentally. You don't feel good physically, you can't feel good mentally and it works vice versa too. So this way you can't just stay sluggish in your nightie all day. You have to get up and get dressed properly, be up and about and that is important. I felt that if you did not get dressed, you maybe don't care to comb your hair, you maybe really don't care if you don't get out of bed. You really just want to sleep all day. By getting dressed, I always try to look my best anyway, no matter how sick I am and I think that is important to keep yourself going.

Maxine: Would anybody say anything or do anything if they saw you still in your night clothes?

Ginger: Yes. I think they would tell you to get dressed because you've got group to go to and you sure don't want to go to group in your nightie. And you would not want to go for a walk in your nightie. So they do say, encourage you that way, you got your program. You should probably get dressed. You know I have lounging clothes that I also wear in here and that is fine too but you're still uncomfortable. If it is later in the evening you want to feel the same at home, something more relaxed and you can still greet your visitors because they too like to see you more, no matter how sick you are, they still like to see you a little cheery. So for me too it was important for me to wear my best colours most often because you are more dreary looking, more tired looking. So it is important for me to pick colours that are bright and cheery. (...) Some of the sicker patients are in their pyjamas but they are in bed more during the day too and that is understandable but for those of us that are in for depression basically, there is no other major..other illnesses attached. It is good for us to get up and get dressed. The nurses are in their street clothes as well and I think first some patients maybe that is a good thing because they can identify better on a one-to-one than to somebody in a white uniform. For me it does not make a difference. You are still a person, no matter what you are. You are still your profession, no matter what you wear. But first time I can see how maybe that can be a blockage to some and I suppose they feel the same way. That is probably why they wear their street clothes.

For Ginger, dress is a cue and is an aspect of "care and treatment" for patients in this ward. She does not identify a problem in distinguishing between nurses and patients. Rather Ginger suggests that nurses wearing street clothes acts to counteract a "blockage" (enhance) of relations between nurses and patients. I suggest this points towards 'making' nurses appear to be more similar to

patients through what seems to be a superficial alteration (what they wear). Ginger goes further and legitimates nurses' actions towards patients in statements such as "it is good for us" where the issue of dress is concerned. Although dress/attire can act as a potent cue (decorations help constitute them as nurses), other features of distinction between nurses and patients appear to be more influential in discriminating between a nurse and a patient (refer back to p. 4 concerned with dancers' performances). Ginger raises this very point when she contradicts herself in: "(f)or me it does not make a difference. You are still a person, no matter what you are. You are still your profession, no matter what you wear". However, it is important to note that dress/attire, which I read as an artefact, is not the only feature of the constitution of identity in practice.

Geographical location and dress are physical material signs of a patients' formal membership to the psychiatric ward. Here membership of a group stands in contrast to formal membership to the ward. This is one of my organizational devices to help make my narrative/writing clear. However, an examination of interaction between nurses and patients reveals that beyond surface characteristics of formal membership other aspects of a patient's identity are apparent. For example, a transformation of a patient's identity is constructed by nurses talk during "community meeting" which is addressed later in this chapter. Having described persons located in the psychiatric ward I now turn to examine how nurses accomplish care practices with patients admitted to the psychiatric ward. Performance is important (see Chapter 1).

Surveillance

Nurses appear to have three methods to help in their organization of patient care. These include: surveillance (Foucault, 1977; Foucault 1980), enrolment (Latour, 1986; Latour, 1987; Law, 1986; Callon, 1986) and the threat of sanctions (Giddens, 1984; Foucault, 1977; Foucault 1980). The following discussion arises from highly routinized day-to-day practice of nurses work with patients on this ward. In this Chapter, I delineate surveillance activities as they emerge from day-to-day practice. In Chapter 5, further activities of care (enrolment and the threat of sanctions) are addressed.

Activities of surveillance are ongoing practices for nurses and occur in combination with a variety of day-to-day activities in this site. In their interviews nurses provided examples of surveillance practices which are both 'formal' and 'informal'. One form of surveillance practice may be formalized by doctors orders. Formalized surveillance is organized on four levels:

> **General**: You may leave the ward unaccompanied for one hour. You must remain on hospital grounds. You must inform your nurse and sign out in the designated book.
>
> **Close**: The assigned nurse will be in visual contact with you every 30 minutes. You may leave the ward only when accompanied by hospital staff.
>
> **Very Close**: The assigned nurse will be in visual contact with you every 15 minutes. You will wear hospital clothing only and are not permitted to leave the ward.
>
> **Constant**: The assigned nurse will be in visual contact and in close proximity to you at all times. You will wear hospital clothing only. You are not permitted to leave the ward.

These four formal "levels of observation" ('surveillance practices') are documented in hospital policy and procedure manuals. These standardized surveillance practices depict a range in frequency of 'looking at a patient' (assessment/observation). Further the manual/policy identifies "privileges" of patients, such as whether or not members of Bestcare are required to accompany patients outside the boundaries of this hospital ward. In contrast, surveillance as conducted by nurses on a day-to-day basis may be more informal and is commonly identified by them as "assessment" and "observation" (see also Nurse Alison, p. 47). I suggest that as such, nurses language-in-use renders 'observation' activities as though benign, but, as I will show, practices of surveillance have effects. However, nurses and psychiatrists informed me that surveillance is intended for the protection of human life. So, for example, surveillance is formalized as an activity of care in hospital documentation sources to "prevent patients from harming themselves or someone else". Further, nurses and doctors also legitimate surveillance as protection in terms of a 'threat to patients safety or the safety of others'.

Patient explanations of surveillance practices emerge from interviews and include the following responses: "because I was really depressed"; "they want to keep track of where I am"; "just so they [nurses] know where I'm at"

and "I wanted to kill myself when I came in here". Typically a patient graduates through a formal surveillance scheme (sequential) based on changes in his/her behaviour as noted by nurses and authorized by his/her doctor. Nurses also informed me that they exercise some judgement in reducing the time period during which a patient is not visible to them (increasing the frequency of the prescribed surveillance). All prescribed "levels of observation" (surveillance schemes) are recorded on the patient's chart, retained at the nursing station. With the exception of the 'routine' designation, each of these surveillance schemes has a corresponding schedule to document recordings of the 'location of the patient' being monitored and a 'nurse's initials' who conducted that particular surveillance check. These occasions are not times which nurses interact with patient rather they, 'check by looking'. Nurses log the time (ie. 1015; 1030; 1045) and note a patient's location (ie, TV room, lounge, recreation room, laundry room). As noted, identifying a formalized surveillance practice (ie. routine, close, very close and constant) is accompanied by other day-to-day activities within this ward.

An array of work routines conducted by nurses underline these surveillance designations and create more informal, and I suggest subtle, ways of surveying patients. In some cases, day-to-day practice is routinized and as such provides opportunities for informal observation and surveillance practices on patients. Routine surveillance activities conducted by nurses include the following practices:

> ... circulating from patient room to patient room and accounting for patients at beginning of each duty shift;
>
> ... keeping records of the number of patients on various observation levels for nursing supervisors (hospital records);
>
> ... having patients report to the medication room at their prescribed medication times;
>
> ... having patients report to dining area for meal times (if a tray is left in the cart then nurses search for the patient who tray was sent for);
>
> ... monitoring attendance at 'community' activities;
>
> ... congregating patients in common areas of the ward during day time hours;
>
> ... monitoring patients' 'signing in' and 'signing out' in a registry kept on the nursing station counter as they come and go from the ward;
>
> ... escorting patients to community activities outside the boundaries of the ward.

These day-to-day practices illustrate that nurses work to survey patients routinely gives access or enables a nurse to access patients. In addition to the day-to-day practices identified above, the geography of the ward facilitates surveillance. The common area of the ward (all patients have access to) is centrally located and visible from most locations inside the boundaries of this ward. Patient rooms are located around the perimeters of the ward with large windows into each room. Nurses also instruct patients to locate themselves in the communal area of the ward (outside of their assigned rooms), except during night time hours and during scheduled "community" activities.

Centrally located in this ward is a glass enclosed room used almost solely by nurses. On rare occasions doctors stop here to speak with nurses. This is the space which nurses occupy and utilize for their discussions with one another. Thus as nurses meet with one another, patients are visible to nurses and nurses to patients. During discussions with one another, nurses frequently verbalize comments to one another from this central location concerning activities visible to them from inside this room. I frequently heard this practice during the collection of ethnographic material. For instance: "(l)ook at that little brat now"; "there's Dr. Riley now"; "who is that talking to Ruth at the nursing station?"; and "where is Gwen going?" are comments nurses make from within this central, glass enclosed room as they look outward to the visible communal areas of the ward. One visiting student doctor describes looking into activities inside this central room as a "fish bowl".

Similarly, patients comment to one another and to me about nurses' work inside this glass room from the common area of the ward. During one community activity patient Patsy suggests passing on anecdotes to nurses present with other nurses "when you have your little discussions, in your little four walls, in there". I suggest that Patsy reveals some awareness concerning nurses work with one another. Patient accounts of nurses work emerging from interviews with me include the following: "I don't know what they do in there but you can see them in there working"; "they work really hard they write in the charts and talking ... you see them from here"; "I imagine it's all medical things, I don't really know but ah, they are doing what they need to I am sure";

and "they smile and laugh .. looks like fun too, it is not all serious. They are people too." There is a two-way visibility.

The foregoing descriptions suggest that the geography of the ward provides a mechanism for nurses surveillance work on patients. Nurses' discussions with one another are undertaken to provide aspects of surveillance even though nurses may not be looking outward from this enclosed glass room. At first sight, therefore, surveillance practices in this site resonate with those Foucault (1977) identifies in his analysis of the panopticon concerning both its geographical likeness and power effects (Turner, 1987). Through instructions nurses legitimate where patients are to be located. In turn, nurses' surveillance practice incites patients to discipline themselves and locate themselves as instructed, in the common areas with other patients. An understanding of surveillance is crucial to patients' and nurses' actions within the ward. This resonates with the significance of Foucault's analysis of the panopticon as a metaphor where persons internalize a disciplinary system in order to keep themselves in check. Foucault states that disciplinary power:

> is exercised through its invisibility; at the same time it imposes on those whom it subjects a principle of compulsory visibility. In discipline, it is the subjects who have to be seen. Their visibility assures the hold of the power that is exercised over them. It is the fact of being constantly seen, of being able always to be seen, that maintains the disciplined individual in his subjection. And the examination is the technique by which power, instead of emitting the signs of its potency, instead of imposing its mark on its subjects, holds them in a mechanism of objectification. In this space of domination, disciplinary power manifests its potency, essentially, by arranging objects. The examination is, as it were, the ceremony of this objectification (1984, p. 199).

As indicated by patient accounts, patients are knowledgeable that they are being watched and they have to know that there is at least a possibility that they are being watched or the surveillance does not have the same effect for acting as a discipline for patients. Patients cooperate with activities of care which nurses practice in relation to surveillance.

Routine surveillance is a practice of power which recursively instils a discipline of norms of behaviour through the gaze of surveillance (Foucault, 1977). This occurs as if patients are under the ever present and watchful eye of surveillance by nurses. The two-way visibility (from inside out and from

outside in) enhances the possibility that at any particular time a patient may be visible to nurses and vice-versa. The patients' knowledgeability that they are being surveyed may be sufficient to produce disciplined obedience and patients pick-up ('learn') that disciplined behaviour has beneficial consequences. Even if it is only to find the path of least resistance, the inducement is for patients to survey themselves. In this way, patient conduct outside the enclosed glass room aligns with 'do patient' performances. On the other hand, nurses conduct inside the enclosed glass room is aligned with 'do nurse' performances.

As should be now clear, it is the geography of this ward that facilitates surveillance practice of nurses and patients, a matter which is further enhanced by other routine practice of nurses. For example, nurses conduct 'team approaches' to surveillance. In reference to nurses circulating from room to room identifying each patient at the beginning of each duty shift, patient Willard suggests such a team approach during an interview when he states that: "they all come in here, in force (smiles) ... in the morning".

Another example of nurses' surveillance of patients arises when nurses attend scheduled activities. Here nurses make mental notes about patients in attendance and about "which patients' talk to other patients" during the activities. These anecdotes are subsequently reported to other nurses during nurses' discussions. This exemplifies a difference in the work space of nurses and patients, and contrasts with that of nurses alone which will be addressed in Chapter 7. Hence, while not all nurses are present at all activities, they exchange anecdotes about patients and their interaction. Nurses rely on one another to contribute information about patients during activities that nurses do not attend. Instances and variations of team practices of nurses already identified include: nurse Alison's account of a 'typical day' (pp. 46-48); formalized surveillance practices; and are also mapped out in Table 1 (meal times; kardex; duty shift reports; post-group and so on p. 51). For the purpose of this discussion further descriptions of variations of team surveillance practices will not be referred to, except for nurse team practices concerning the distribution of medications to patients.

Provision of medication

Another designated activity of care concerns the provision of medications to patients. I suggest that the provision of medications conceals part of the apparatus of surveillance: this is a routine activity which enables nurses to survey patients at pre-specified times. Doctors' authorize medication regimes for each patient, and nurses distribute, and/or administer these medications to patients. This is one practice which produces the conjecture that each patient is handled 'as an individual' in this ward, in that, each patient ostensibly receives medications intended for them. Such a practice reflects the claim of hospital members that patients are treated individually.

Patients who are prescribed medications are expected to take these medications. During the collection of ethnographic material, patients' failure to cooperate with prescribed medication regimes resulted in threats of discharge from the hospital or patient transfer to a facility where incarceration includes provisions for medications being forcibly given to patients. Such sanctions indicate that medication therapy is compulsory when prescribed by doctors. In this regard, sanctions underline a putative idea of community.

Medication is routinely administered at four specified times each day (refer back to Alison's account p. 46). Usually medications handed to patients, arrive on the ward from pharmacy already divided into containers for each patient. In this form nurses hand out the medications to each patient. At these pre-established and standard times, a nurse assigned to the medication duties for the duty shift positions her or himself central to the boundaries of the ward and loudly vocalizes:

M E D I C A T I O N T I M E.

This same announcement is employed at meal times calling out: BREAKFAST TIME, LUNCH TIME or SUPPER TIME. At these times, patients who know that they are to take medications queue up at the medication counter, literally a hole in the wall out of which a nurse appears and disappears following the hand out of medications. By this means, nurses constitute distance between themselves (with medications) and patients on the other side of the wall waiting for hand-outs.

Patients become disciplined at presenting themselves at the appropriate times to receive their prescribed medication. Nurses draw attention to patients who 'queue up' with each "MEDICATION TIME" call from nurses. For instance, during kardex discussions amongst nurses, patient Al has been discussed in terms of following other patients and activities that he is not expected to be involved with and is identified as being "anxious" when he gets turned away by nurses. On one occasion the following comment is made by nurse Laurie:

> Laurie: He's still coming for his pill every every time, ah, but he's not as anxious as he was yesterday. Like he took it fairly well when I said "No there's nothing here", [he said] "okay" and left and never came back, so he is a lot less anxious.

Laurie indicates that when patient Al is informed that "no there's nothing here" that "he took it fairly well (...) [he said] okay". Although the discussion is framed around Al's acceptance of not receiving medications that other patients were receiving, I suggest that the issue centres on cooperation and discipline. In other words, patient Al is displaying disciplined behaviour and, most importantly, his ability to do so is correlated by the nurses with his return to wellness/normality ("he's not as anxious").

Patients are cued to the practice of MEDICATION TIME first by the call from a nurse and secondly by the movements of other patients. In relation to the above case, Al notices other patients responding to the 'medication call' by lining up and others join in. Al's actions also illustrate what might be described as cooperating 'well'. The fact that Al has no medications prescribed is not a problem for nurses, as they set aside the issue that he presents himself on each MEDICATION TIME call. This situation does not cause problems for nurses, just Al, who lines up for nothing.

This medication routine is referred to by nurses as "self-medication". However, 'the self', as 'a patient' appears to be merely responding to cues surrounding nursing practices of distributing medications to a number of patients who cooperate with a time saving device for nurses. Here, patients cooperate with the nurses way of organizing medication therapy as prescribed by doctors. As part of the apparatus of surveillance, medication time, illustrates the effects on patient Al to be disciplined and queue up at specified times.

Moreover, Al's case reveals how 'formal' aspects of practice concerning medications are taken up, 'informally' and accomplished socially.

One reading of the giving of medications is that they are ordered by doctors and are a (menial) part of nurses' work. This reading, I suggest, is simply a functional explanation. Instead, as a task assigned to nurses by doctors, nurses transform this activity into a legitimate way of undertaking routine surveillance. In this way, nurses' effect benefits in the name of distributing medications.

Other aspects of the constitution of a patient identity are now discussed.

Transformation of a patient's identity

Patient attendance at 'community meetings' illustrates a crucial transformation of a patient's identity towards legitimate membership to community. This changed ontological status of identity (person-as-patient) marks the change from 'a patient' to 'a member of community' (person-as-member-of-community). The selection of nurse Leona's words of "you come to Community Meeting" ; "we go downstairs"; and "we do crafts together" captures this transformation (refer back to pp. 54-55 and 67) for full excerpt). Patients congregated at this particular time are compelled to conceive of their identities, formerly as one of a patient, now, as a member of a more "important" group referred to in this setting as "community". Relating to other studies where membership is discussed, Latimer (1993) shows how patients do not have legitimate membership and their movement from rehabilitative states to discharge is effected by the absence of such status (p. 251).

In relation to previous interview transcripts, nurse Jennifer (pp. 63-64) and patient Ginger (pp. 79-80) also stress the essential nature of transformations toward healing when they discuss 'attendance' and 'encouraging' patient attendance in day-to-day activities. In these examples, patients are compelled to perform such a transformation as nurses direct and monitor changes in performances of patients on a regular basis. Such monitoring is addressed in this thesis as it pertains to surveillance and the enrolment of patients into community during nurses' work activities (ie. kardex) presented in the next three chapters.

A transformation of a patient's identity also signals an expected change in a patient's understandings of themselves (self-identity). In Cohen's (1994) recent examination of the self he addresses how it is important to not conflate one's perception of self with that imposed by another. Cohen claims that there is a:

> clash between a person's sense of self and the identity imposed on her or him, a conflict which is essentially about who has the *right* to define an individual's identity (p. 178).

Cohen emphasizes that "social scientists have been wrong in treating personal and collective identity as the products of social relativities" (p. 180) as though persons can simply be viewed as an outcome of social relations. Similarly, Cohen points to contemporary organizational and management views where organizations are portrayed "as 'cultures' which shape their members' behaviour" (p. 92): an "organisation's assumed capacity to confer identity on its members" (p. 93). In the ward, patients are expected to alter and work on their own conception of themselves as patients to become part of community, a member. Such a change in a patient's self-identity is "important" so that patients will 'fit in' to community in this ward. Nurses mark out an image of community and with some effort on the patient's behalf to 'fit in', the smooth flow of day-to-day practice is accomplished. This process of translation of nurses' interests into patient interests moves members towards that commitment to community which is advertised by nurses.

The excerpt from community meeting (see pp. 54-55) illustrates the expectation of a transformation from patients' viewing themselves as a 'patient' to a 'member of community'. This transformation to a 'member of community' is reversed in: "they go to the park". Here, members making up community are reduced to "they", patients. The former transformation from a person to individual patient is currently illustrated from 'patients' to 'member's of community'; and talk of "they" (in reference to patients), enables the organization of a number of members where patients are treated the same without special privileges to individual members. Collectively, as can be seen in the excerpt from Leona, patients are referred to as "they".

This example reveals that some patients, those currently congregated in this community meeting have a group member identity. It is important to note

that not all patients currently assigned a formal status as 'patient' in this ward are present in this community meeting. This raises a number of questions: 'How is such inclusion and exclusion of patients accomplished?'; 'How are patients assessed in the day-to-day practices of nurses?'; 'What do these different forms of membership reveal?'; and 'Is such a status decisive?' I now turn to examine 'membership' and how membership is constructed by nurses in this ward.

Membership status is provisional

Day-to-day practice reveals that a primary feature of community centres on the provisionality of membership. There is an elasticity to membership; all patients are potential members of community on this ward and anyone at any time can default or be dropped out. During nurse to nurse contacts and patient to nurse contacts, all patients are talked about as being a part of community. However, a difference in the enactment of community emerges when patient attendance at activities is examined. Whether or not a patient attends activities displays his/her status in terms of legitimate membership to community.

In practice, all patients are given the formal status of 'patient' but, in addition, some patients are 'up for' a 'group membership'. This is a stable feature of community within this setting. Stability is within the control of nurses, as nurses are the gatekeepers for community as practiced inside this setting. In contrast, an ambiguous feature of community is its provisional nature. Here nurses as the gatekeepers also enjoy the advantages of ambiguity in that, they sustain a 'collective' sense of community where the patients may or may not be permitted passage. Nurses are the 'obligatory passage' (Latour, 1987, p. 4) to community. The continual play between these two contrasting notions (stability and ambiguity) works to perpetuate or allow leeway (ambiguity), as well as to construct limitations on which patients are accommodated as 'members of this community'.

I suggest the provisional nature of whether a patient is characterized as 'in' or 'out' of community organized by nurses is reflected in nurses talk during kardex:

Jody: Michael Murray, oh boy.

Nora: Ah, I asked him about coming to group to see and he is just not ready for it.

Jody: No.

Nora: So I just said that "I will talk to you in a day or two about it". (. . .)

Jody: It might not hurt to have him on a .. is he a risk at all?

Alison: Ah, uhm... he signed a note to stay in hospital ah ... it might be worth a thought because he is so withdrawn. . . He hasn't, ah, he won't even talk, not even one word, he just shakes his head and

Jody: Even if it's a ... we are doing checks on him, you know, its some kind of stimulation on him ah every half hour or so,

Alison: yeah

Jody: to bring him back, it would be easy to loose contact with him he is so withdrawn and so quiet. (. . .) [moved on to discuss the next patient listed in the kardex registry]

This excerpt reveals nurses' concern for Michael. Nurse Nora states that "he is just not ready for it" (group activities) and that she will talk to Michael "in a day or two about it". Such a stance suggests that Michael may or may not have been invited to attend. However, what Nora claims is that 'he's just not ready for it'. Jody's inquiry about whether Michael is "a risk" pertains to a 'matter of protection against him harming himself and/or fleeing the ward'. Alison indicates that he "signed a note to stay in hospital" but that does not necessarily convey that he will not harm himself. Patient Michael is discussed by nurses in the next day's kardex discussion:

Jody: Michael?

Nora: Michael! Uhm, I talked with him this morning, he refused to go to the activities. Still, refusing to go to group too and I wanted to see if he would go to that. Ah, he is quite guarded and, . . . you know, I just tried to talk with him superficially and he has a hard time with that.

Jody: Is he psychotic?

Nora: Uh, I don't think so but

Amy: It sounded like it to me

Nora: Ah, yesterday he seemed sort of a lot more preoccupied and stuff, his concentration today, he says, and he is less preoccupied with other things. He looks, he maintains eye contact and ... you know, he can hear what's going on now. And he was isolating himself most of the morning and then later I saw him playing cards with Ruth. So, um, Dr. (laughs) Marshall saw him and ... I don't know, he is referred to Social Services but they are suppose to be phoning me back, I haven't talked to them yet. He's certifiable [section-able] I guess, if he tries to leave. He wanted to leave on Friday because he is suppose to start back to work and he has ... like he needs to work, he says "For his financial things" like he has got bills piling up and stuff. So Dr. Marshall thinks he can get money from Social Services, but I kind of doubt it. Anyways ...

Tina: He doesn't have any sick benefits or anything?

Nora: No. So anyways, I haven't really talked too much once Dr. Marshall told him that he "Can't go home" (laughs).

In relation to membership this excerpt reveals that it is not a question of whether Michael has been invited (as in the previous day's discussion): 'he is refusing'. These two excerpts discussing patient Michael indicate that he is "guarded" but nurses are considering and expect that he will be able to attend group once he is not 'guarded'. Nurses have observed him playing cards with another patient, Ruth, which serves as evidence for the nurses that he is not "so withdrawn and so quiet" as he was reported to be on the previous day by nurse Jody.

During the latter excerpt concerning Michael, nurse Nora also indicates that 'they' (nurses) still have some time to convince Michael to attend community activities which she laughs about stating: "Dr. Marshall told him that he can't go home". Provisionally, Michael does not have a 'group membership' status but nurses have time to work with him towards such an achievement. Michael is not ready yet, but, nurses plan to transform him (translate their interest into his) from a 'patient identity' to a 'group member identity'. I suggest this exemplifies one way in which patient identity is always running ahead. These excerpts reveal that nurses are accustomed to providing some patients with "a day or two" to feel comfortable but they expect these patients will eventually fit into community activities.

These excerpts also give rise to nurses legitimating, in this case Michael's exclusion from community, in that he is "guarded" and "withdrawn". Additionally, nurses are concerned with whether he is cooperative about staying in hospital and it would be difficult for them if he was disruptive in community. This supports the view that nurses do not include patients who are disruptive. Such discussion by nurses reveals them settling on the 'inclusion or the exclusion' of patients as members of community. Nurses do this work of settling on a patient's status in community through the development and exchange of nurses' accounts during their activities of kardex. As shown, nurses construct accounts for patient membership status. I now turn to investigate further aspects of how nurses legitimate membership.

Physical or mental factors "just not well enough" or "too sick"

The question of membership for nurses is worked out differently, at different times, concerning patients. Sometimes accounts of membership status of patients may be based on or identified with 'physical' or 'mental' characteristics. In addition, a nurse's approach to a patient takes place at various times of a patient's hospitalization. In this way a nurse's practice of introducing patients to community may occur just prior to community meeting while other patients receive information about community during their admission interview to the ward (conducted by a nurse). Yet in other instances, based on nurses' previous experiences with an identified patient, little or no current information is required for nurses to automatically 'exclude' a prospective patient from community membership. In line with Strathern (1991; 1992) there are partial distinctions, but they are not fixed, and partial connections which are also not fixed. Hence there is a play between ambiguity and stability of conditions defining a patient's membership at any moment and time. For instance, an auxiliary staff member, Tess enters the conference room where nurses are conducting kardex and Tess states:

> Tess: (Tess enters conference room) Guess who's coming to dinner? (laughter in room)
>
> Tina: Bertha? [several nurses say same name]
>
> Alice: They didn't commit her?

Tess: you're all psychic [although it appears that Tess considers these nurses as "psychic", these nurses were notified earlier by Dr. Riley in the Emergency room that Bertha had presented herself in the Emergency room. They were also informed that Dr. MacIntosh was to have spoken with Dr. Riley to have Bertha "committed"/ sectioned at Shady Pines rather than admit her to Bestcare]

Leona: What did they do, discharge her?

Alice: they were going to commit her

Samantha: Yeah, they even wrote up papers on her downstairs.

Leona: Why are we going to have her back? We don't do anything with her.

Tina: We should send her to Shady Pines.

Alice: She is really bad. Dr. Riley was telling us this morning that she was just really, really awful. The family or the sister phoned...

Leona: But we don't do anything.

This excerpt reveals that patient Bertha is already 'known' and nurses deem her un-suitable for membership to community even prior to her formal admission to the ward. The nurses settle on their account of Bertha as someone "we don't do anything with" and as "really bad (...) just really, really awful". Importantly, Bertha had not physically arrived on the nursing ward before nurses determine her exclusion from community. Again, this illustrates how a patient's identity is always running ahead. This constitutes an exclusion which hardly needs to be made explicit because she was not invited and not included. Bertha arrived on the ward later this day and she continued to be 'excluded' for a ten week period, the duration of her hospitalization.

Another patient Ret is excluded from 'membership status to community' during his hospitalization. In this case nurses legitimate his exclusion because Ret has what they refer to as 'physical' limitations. How particular "physical needs" can constitute characteristics for exclusion emerges an interview with nurse Zana:

Zana: (...) know what it is you want to do with that patient throughout the day uh, usually this is through, the patients are having breakfast, there's AM activity that goes on in the morning and all appropriate patients are encouraged to go. I guess by

> appropriateness, uh, ones with the ability either physically or emotional that can function with the program that's going on in the morning. (...) we sometime have a lot of patients that, let's say alcoholics that have come in that we have to attend to their physical needs first before we get to their emotional needs, so you know in all aspects everybody's physical needs are, are attended to first before their emotional. (...) Ret is quite in need of physical treatment, uh he's an alcoholic, been a chronic alcoholic and is suffering quite severe withdrawals for the present (...) top priority initially is assuring my patient that is the chronic alcoholic that his physical needs are going to be attended to, he is getting his meals, he's being assisted to the bathroom and back, that he is being kept clean, uh that he is being given the proper medication at time when needed for his alcohol withdrawals, uh. . . like I say the physical needs come first (...) He has got to get his physical aspects looked after first before we can look at the emotional.

In her account, Zana detaches physical from emotional needs and in doing so, relegates physical needs to a different domain than that of community. Zana claims that patient Ret's "physical needs first" are a "top priority". However, Ret is excluded from membership status throughout his hospitalization. This raises to the surface another consideration of nurses not apparent in the above excerpt. As noted by nurse Jennifer (pp. 64-65) patients are also viewed as 'legitimate' or 'illegitimate' and in Ret's case, he is not a legitimate patient for community based on nurses' construction of him as "an alcoholic" and "he'll be back again in worse shape the next time. He's admitted again and again and nothing ever changes". Similarly Rosenthal, et. al.,'s (1980) analysis of what nurses view as problem patients suggest that "career patients" are "non-legitimate" (p. 28). They state:

> in many cases, the fact of hospitalisation itself is considered non-legitimate, either because patients are thought to be 'career patients' who seek out hospitalisation for its own sake, patients who enjoy hospitalisation, patients who are not really sick or patients who have fully recovered and therefore have no reason to be in the hospital (p. 29).

Nurses view Ret as a career patient. This hinges on the diagnosis assigned to him, alcoholism. Nurses' hold out minimal hope for him to sustain sobriety upon leaving Bestcare as he will be admitted to hospital "again and again".

In another example, a patient, Gwen, has worked out how 'physical' constraints are the salient condition(s) for her not being invited to attend community activities:

Gwen: Oh, this morning they went bowling and they didn't ask me.

Maxine: Would you like to have gone?

Gwen: Yeah. (...) Maybe they thought I couldn't bowl if I came. I can't get along without my cane, I am afraid of falling. . . they discourage me or something.

According to patient Gwen she was not invited to attend this day's activity. Her perception is that nurses "discourage" her attendance. This patient's view is that her 'physical' restriction and use of a walking cane prevents her from being included as 'a member of community'. Gwen has a formal patient status in this ward but not in community.

The second group of characteristics which nurses legitimate as conditions for non-attendance at community activities pertain to a patient's 'mental state'. In these cases, nurses exclude patients from membership to community on account of: "she can't socialize"; "she has been institutionalized for years"; "she is a chronic patient"; "she is high"; and "he can't sit still". Other comments such as "she's too weepy yet"; and "he is too psychotic still", however, underline the provisional status of a patient's membership in community based on their 'mental states' and behaviours. In these cases, nurses' accounts indicate that they are constantly assessing patients as the language such as "yet" and "still" underline. Such characterizations legitimate nurses' displacing patients from community as persons.

It is also important to examine how patients' are involved in practices of 'inclusion' and 'exclusion'. As participants in the day-to-day, patients have an effect on their own membership status as 'in' or 'out' of community. According to nurse accounts the practice of exclusion arises from nurses not encouraging attendance by reasons of a patient's own actions. For example, patients who will not attend are identified by nurses as those who "resist treatment", or who are "resistive". As already noted, on one occasion during kardex, nurse Nora asks "What about Michael?" and nurse Tina responds "he is just not ready for it" (p. 106). This suggests that something about Michael is preventing him from being asked by nurses to attend. Transforming Michael's patient status to one of a group membership is weakened by the suggestion of Tina. Subsequently, a patient status for Michael is reified by the absence of comments from other

nurses. This suggests Michael is acting in ways which are characterized as being withdrawn (not talking; being quiet; refusing to go to group); he is not for community in a particular way and thereby excluded. In practice, Michael retains a patient status. However, Michael may be said to rule himself out. Similarly, Gwen can be said to exclude herself on the grounds of physical restrictions. In Michael's case, he has not been granted membership but he has been reviewed by nurses as a potential member of community. That Michael is discussed by these nurses underscores the potential for movement with him. This instance also demonstrates that such a categorization is provisional with "not ready yet".

An examination of characterizations nurses make suggests that not all patients are worked on to produce a group member identity. Patients are also constituted by nurses as having some effect on whether or not a group membership is availed to them. Nurses consistently identify signs or characteristics of physical and mental wellness to work out legitimating evidence for the question of patient membership to community. Labels such as "psychotic", "high", "weepy", "depressed", and "manic" are among the labels nurses use to illustrate that patients are not suitable for membership. In these ways, nurses constitute exclusion and displace patients as persons. Both physical and mental characteristics feed into the action taken by nurses to construct a patient's identity or as a group membership status; each of which are predicated on "suitability". The criteria identified by nurses and patients during interviews with me rest on a patient's suitability. This is made explicit by Tina when she identifies "suitability (...) and the type of group":

> Tina: (...) suitability. It varies according to the type of group you do. Right now it is a psychodynamic group. They are not in crises but they are able to take in some information, they are not psychotic. Uhm motivated to work on interpersonal aspects (...) Able to take something in, listen and take something in. Those that don't, are for example preoccupied with their own thoughts, ah.. not taking in information, not the motivation.

Ethnographic material reveals that "suitability" of patients is based on the capability of a patient to be cooperative (and non-disruptive). In this way, cooperation as constituted by nurses, suggests that a patient communicates in particular ways rather than in others. As shown, 'being weepy', 'withdrawn',

and 'not talking' are all taken as unsuitable forms of communication. These unsuitable forms of interaction delimit a particular patient ontology. The importance of cooperative behaviour is something which patient Ginger identifies during her second interview with me:

> Ginger: I noticed there was a patient today, just not going to go and he did not seem to have any particular reasons. He had excuses, but, not definite reasons. Fine, if that is, if you are not going to look for help you are not going to get it. If you are not going to cooperate, why should they cooperate with you because there are other patients who do cooperate. So, it depends on how much you want help too, how much you are willing to cooperate.

For Ginger "excuses" are not legitimate "reasons" in: "he had excuses, but, not definite reasons". Ginger claims that if "you [patient] are willing to cooperate" that nurses will "cooperate with you" and that there are patients who are willing to cooperate. This suggests that there seems to be a 'difference' between those who are perceived as not able to cooperate and those who are deemed to be not cooperating. Once invited to attend, cooperation is central to receiving help in community. It is important to note that patients' actions (exhibited mental and physical states) and nurses' actions (identifying characteristics of the mental or physical states) within the context of community both contribute to the constitution of membership status for patients.

To this point in the discussion, my analysis elucidates: a person is given a formalized patient status upon arrival to the hospital ward; surveillance practices of nurses underpin nurses work with patients; doctors are distant from day-to-day practice of community; membership status for community is constructed by nurse and patient actions; and membership status is provisional (which underlines the mobility rather than stability of such a status). This discussion also reveals that some patients attend and some patients do not attend community activities. The transformation from one status to another suggests that activities for a person with 'patient status' are different from a patient with 'group membership status'. Therefore it is important to examine cases representing both of these divisions amongst patients. However, first I would like to address: 'What happens to patients not included in community activities?'

Care of patients excluded from membership

As suggested by the above discussion a number of patients are excluded from obtaining membership status gained only through attending activities organized by the nurses. The matter of exclusion is not trivial. For example, in one week with a census of 14 patients, 8 were excluded. Based on accounts from nurses and patients and analysis of observational research material, although patients are excluded from community membership, they still receive three primary care activities from nurses. However, these can be understood as 'minimal care effort' activities. They are highly routinized and nurses utilize team efforts to conduct such day-to-day practices. These practices include surveillance, custodial care and medications. Zana talks about custodial management practices (pp. 110-111) pertaining to patient Ret (ie. bathing, eating, safety). Surveillance and medication practice already presented in this chapter apply to patients who are excluded. However some further details for patients excluded from membership are now discussed further.

The combination of these three approaches by nurses to patients effectively leads to producing patients who are patently, docile bodies. Patient passivity is produced partly through instructions from nurses and is purported to be aided by medications aimed at 'settling' patients down. Patients are disciplined through nurses instructive practices inside this ward. The overall effect is to produce patients who competently demonstrate discipline. Examples of nurses' instructions to two different patients include: "button up your shirt Josh"; and "Andy, go to your room". These examples of docile bodies signal the exclusion of these patients away from membership status to community organized by nurses.

In the following excerpt nurse Jennifer is talking about the differences between patient Bertha and another patient that Jennifer is assigned on this particular day:

> Jennifer: She [Bertha] is a chronic schizophrenic and she's been with us almost two months awaiting placement. (...) Uhm, her main problem is that she's not functioning well in the community. She doesn't take her oral medications. She's on a weekly Depo. She doesn't you know, look after herself, bath or clean up her room or anything. So when she was brought in last time she was filthy, malnourished. Bertha had been in an institution for a number of years up until about three years ago and at that time there was a

change which meant that the institutions were looking at keeping patients like Bertha and wanted to get them back into the community. However, Bertha isn't fitting well into that idea and she really does need to be in someplace ... the only problem is she's still a voluntary patient and she doesn't have a legal guardian. So she can refuse whenever we suggest that she go to this place or that. So at present time Dr. MacIntosh is working at obtaining a public guardian for her and then at that time we'll say, "OK, this is where you have to go. You have no choice". (...) She smokes a lot of cigarettes, watches TV, she tends to sleep during the day and stay up all night. The nurses on nights encourage her to go to bed by taking away her cigarettes or removing the coffee pot. On occasion they give her some sedation at bedtime but that's not usual. Bertha has sort of her own idea of what she wants to do. She gets sort of more psychotic when you try and put limits on her, but she will comply if you do ask her to do things. (...) Hmmm ... I think if they're here all the time you don't pursue their treatment as actively. But I'm not sure if that's just because you're used to the person or the treatment that they need isn't active treatment which is what we normally do with our patients here. Like it's basically just basic nursing care ... which making sure they're safe and trying to encourage them to bath at least a couple times a week and regulating their medications. But we don't do a lot of one-to-one therapy with them.

Maxine: How much contact would you have with Bertha today?

Jennifer: Well, there'd be the number of times you give out medication that you'd be talking to her directly, calling her for meal time. . . She will get her meal tray and put it down on the counter in the lunch area and she'll wait for everyone else to eat and then she'll come and get her tray or she'll take it to her room or some stay, put it at her doorway... the other patients usually take their tray and sit in the dining area with at least one other person. (...) I don't really remember when there was a change, if that's always been kind of her pattern. It's certainly been her pattern this admission and it's almost ... like she almost has the staff trained. We all know to put her tray on the counter cause later on she'll come. Rather than leave it on the cart 'cause then it'll get sent back downstairs. [suggesting that the uneaten meal will be returned to the hospital kitchen] (...) we feel that really not much is going to change with Bertha that she's not really going to improve more than she is now. I mean this is usually the best ... as good as she gets is when she's in hospital. And in some ways it's easier on us than if we were to insist on her always being at the table and easier on the other patients 'cause it could disrupt their lunch if she were to get really, really angry and things (...)

Jennifer prefaces an account of familiarity with Bertha as a "chronic schizophrenic". Bertha is alluded to as patently, a 'docile body' when nurse Jennifer states: "you don't pursue their treatment as actively"; and "we've [nurses] all got to that sort of stage of being quite familiar with them". Jennifer identifies three other patients on the ward at the current time who fall into a

similar category during this interview. Jennifer claims that "just basic nursing care ... which making sure they're safe and trying to encourage them to bath at least a couple times a week and regulating their medications. But we don't do a lot of one-to-one therapy with them". Jennifer conveys what I read as minimal care efforts including surveillance practice, provision of medications and custodial management. Although Jennifer identifies an 'activity state' as a process, she also suggests that familiarity with Bertha has the effect that "you don't pursue their treatment as actively". In this sense nurse Jennifer implies that 'not pursuing treatment actively' is an effect of institutionalization. Her final statement following along with the above excerpt suggests a discrepancy between how nurses are caring for Bertha and their plan to institutionalize her:

> Jennifer: (b)ut basically I think it's just, there is no real point to it because even if we insist on her following all these rules it doesn't mean that she's going to get more organized or anything with her life in general, we'll just be making her fit into the system but not really to her benefit as far as I can see.

Jennifer states that "we feel that really not much is going to change with Bertha". Jennifer suggests that Bertha will not obtain community membership. More importantly, this example illustrates the social exclusion of Bertha from community organized by nurses on the ward. Discursively, Jennifer is cognizant of Bertha's 'social abilities' and Bertha remains socially excluded from community activities. I suggest that there is an inversion in the 'typical care' relationship between nurses and Bertha. The difference in their relations, ironically, is that Bertha has 'trained' the nurses. As a patient, Bertha belongs in a different way and she permits nurses to access her in particular ways. As a figure, Bertha is constituted as individual rather than a member of community.

The previous interview excerpt continues with Jennifer. I inquire about activities that Bertha is involved with on a day-to-day basis:

> Maxine: OK, what else might Bertha do during her day?
>
> Jennifer: Well, I know that she likes to go down to the lobby and there's a woman friend that comes to visit her. I've seen her come sit with her at times for hours on end. That lady doesn't come up to the ward. And I know she likes to go outside and sit in the sun. Watch the other patients who come in and out of the hospital.
>
> Maxine: Does she talk?

> Jennifer: Well, when I've seen her with her friend downstairs she seems to converse fairly normally. I haven't heard the content of the conversation but there is sort of an interchange between the patient and the visitor. As far as patients on our ward, Bertha if anything just tends to say things that are just quite bizarre. It's almost like she's hallucinating and she's hearing that person say something to her and she'll just shout back something in response to whatever's going on in her head. She doesn't really socialize much. If anything she tends to avoid the other patients.

Despite Bertha being excluded from community membership on this ward, because "it's easier on us [nurses]", she has developed some social contact outside the boundaries of the ward. This 'capability' is contrary to several nurses' discussions about Bertha where she is identified by nurses as "monosyllabic". The contrast with "convers(ing) fairly normally" (noted by Jennifer) acts to undermine nurses ability to assess this patient. However, the important point here is the social exclusion enacted by nurses is legitimated by the nurses' version of community. Bertha has been detached from community by the nurses. And, by way of their characterization of Bertha, she does not want to communicate or mix with other ("stays in room", "quite bizarre" talk and "shouts back"). Bertha's apparent abilities outside the ward with at least one female visitor are not sufficient for the nurses to alter their collective approach with her. Jennifer implies that 'ease on nurses' ("it's easier on us [nurses]") is an important consideration for Bertha's excluded status.

Nurses' exclusion of patients from community enables a smooth flow in day-to-day practice by minimizing disruption: those who do not cooperate with reproducing the ethos in this ward are excluded. The discussions in this chapter underscore the importance of Cohen's (1994) suggestion that, as previously quoted, "we cannot take belonging or social membership for granted: it is a problem which requires explanation" (p. 21).

Chapter 5

Translating community in practice

Two distinguishable 'activities of care' addressed in this chapter are enrolment of patients to community and the threat of sanctions. Here I discuss patients who are 'members of community' and how such membership is produced. Underlying nurses day-to-day conduct is a message that membership to community cannot be taken-for-granted. There is a process of translation at work through which some patients are given the opportunity to enrol themselves. Although community is treated by nurses as an opportunity for all patients, by nurses' own admission, not all patients are granted the 'rites of passage' (Turner, 1967; Turner, 1985) to community. It is an option held out to patients. Talk of community therefore projects conflicting messages in that, what is advertised by nurses as a widely available 'modality' through which patients can heal is also presented as a space for selected patients only. This appearance of contradiction resolves itself, however, when nurses use of community is treated as a device of control.

I examine nurse-patient interaction in order to show how a translation of interests is accomplished to reproduce community. The way in which patients view themselves is altered through such interaction with nurses. However, investigating concurrent nurse-nurse interaction I also show how a translation of interest (Latour, 1987) is facilitated by nurses making judgements about 'who will be given membership status' and a patient's willingness to enrol him/herself through the strategies of persuasion employed by nurses. For example, Lyotard's (1979; 1984) discussions of language games and 'moves' helps to explain how interaction can be examined in terms of 'vested interests'. As enrolled members of community I present material from one particular activity, "group", to examine the production and reproduction of nurse identities and patient identities.

Enrolment to community

The act of patient attendance at community meeting registers that an image of community drawn on by nurses has had an effect on patients. Nurses accomplish this effect in a number of disparate ways. As already noted, nurses inform some patients that "community meeting" is held on Monday morning and these patients are asked to be in the room where it is scheduled to occur. Nurse Norman illustrates the use of a casual approach to patients when he provides the following account to me:

> Norman: (...) Ah, we would like you to attend a meeting for the patients and about the ward. It's community meeting at nine-thirty in room 222 .. ask them to attend this. They just come you know, they just go along (laughs).

He suggests that patients attend although they may not be acquainted with what will be occurring at such a meeting. Patients "go along". Other examples illustrate that nurses' commence work on a patient at the time of a patient's first encounter with nurses on the ward. Hence an array of interaction between nurses and patients is used to advertise community to patients. Importantly, during such interaction nurses employ slightly different strategies to accomplish patient attendance. For example, during an admission interview which nurse Nora conducts with patient Eliot, one nurse's approach to a patient is evident. Also present in this session is Eliot's wife Emma. This portion of the admission interview was preceded by Eliot expressing reluctance about being in hospital at this particular time. For instance, Nora had moved towards Eliot to place an identification band on his wrist and Eliot's response was "no" accompanied by his sitting back in his chair:

> Nora: Okay. So are, are you going to be able to stick around here for a while? Do we have to worry about you running off?
>
> Eliot: Well, I don't know what I have to do here.
>
> Nora: Do you want me to tell you a little bit about what we do? Uhm, I guess each day you'll be assigned a nurse who will be like your nurse for the day. I guess the nursing staff will try to talk with you and help, you know, get some of the feelings that have been happening, talk about the problems, maybe help you come up with some ways to help yourself feel better. So you'll have that sort of one-to-one talking each day.

Eliot: Well, it's not the problem I was looking for a job, I had no job all summer and I was scared to find one and, it just got, I just got frustrated; that's about it.

Nora: Well, maybe we can help you deal with the fears and the frustrations that you're going through. There's also a psychiatrist who usually your regular doctor will refer you. I think you were referred to Dr. Malcolm. She's/he's one of our psychiatrists here.

Emma: uh hum

Nora: So she'll/he'll talk with you and probably you know, probably assess your medications and be sure that she/he thinks those are the best ones for you. Uhm, we have some activities in the morning like, ah and usually just fun sort things, like maybe bowling or you know going out to Botanic Gardens or you know, there are various things that we do each morning.

Eliot: Well, that's not my problem at all

Emma: I think that's to get you going with other people again.

Nora: and sort of get your mind off some things for a while, because you do a lot of introspection and stuff. And in the afternoons we have group therapy.

Emma: uh hum

Nora: Like we try to encourage people, to attend, what we have to offer and that's each day in the afternoon. And then after that visiting hours and stuff start. You can get passes, you know, after you're here a couple of days, if you want to take passes and maybe go look for jobs or visit at home or whatever you need to do, we start allowing that. The doctor orders those when she/he sees fit. Sometimes people even get passes for the whole weekend, things like that uhm

Eliot: That's not my problem at all, though...

Emma: I think you have to learn to get along with other people again and not to be so scared and get that out of your system, because you don't want to talk to anybody and that's no good. You're very scared to go for a job, because you think you can't do it. So I would say that you should talk with the psychiatrist and the nurse.

Nora: You know, you can, you don't have to dive right into this. We can sort of take it as...hopefully after you've been here a day or two, you'll sort of relax a little more and feel a little more comfortable around here and see how things work and. Anyways (sighs), I guess I can take you around

> and show you where everything is and stuff (...) Lets put this on now (as she moves toward Eliot with an identification band).

This excerpt reveals a variety of notions conveyed by Nora and shows how patients entering the hospital ward are enabled to catch on to what sort of identity they can make for themselves within the ward. For example, this interaction is a location for examining instances of nurses employing an image of community as well as, how patients are assisted to see themselves as a patient (ie. persons-becoming-patients). Above, Nora draws from community to facilitate her work to change the way Eliot conceives of himself. Nora competently helps to constitute Eliot as a patient and a would-be-member of community. This transformation includes identity changes from individual people preceding admission to the ward, to a patient identity on the ward and finally the transition to a group member identity. Evidence for identity transformations are reproduced in the daily discussions which nurses conduct with one another on the ward. Patients are subsequently related to or approached by nurses not as an individual patient but as a member of a community. It is important to note that patients enrol themselves into community while nurses move them around to see the benefits of membership. This hints at a translation of interests in that it is beneficial for all persons concerned. According to Latour (1987), such a process caters to people's "**explicit interests**" (p. 108, emphasis in original). He goes on to suggest that:

> (a)s the name 'inter-esse' indicates, 'interests' are what lie *in between* actors and their goals, thus creating a tension that will make actors select only what, in their own eyes, helps them to reach these goals amongst many possibilities (pp. 108-109, emphasis in original).

This interview with Eliot (as well as nurses subsequent contacts with him) demonstrate how the interests which he brings with him from the external community (and those he displays as a person) are displaced by Nora's current focus with Eliot. In particular he is forced to disassociate himself from what he formerly values as a part of his identity: what he is as a person is displaced. For instance, Eliot states that his problem is that "I was looking for a job" and that this is an important aspect of Eliot's identity (as he mentions this a few times). Although Eliot is not easily displaced, reiterating that what he is offered is "not his problem", Nora continues to displace his interests by

emphasizing the day-to-day activities on the ward. However, this example illustrates that Eliot is not easily displaced. Nora illustrates that the day-to-day activities of this ward over-ride a sense of uniqueness which Eliot expresses during this session. 'Why does Nora insist on Eliot altering the ways he thinks about himself in the hospital?' It appears as though there are different interests: those of provider and those of recipient of care practices. What Nora is doing contrasts with Lynam's (1990) prescriptive philosophy that nurses should integrate 'sick' and 'well' aspects of a patient's identity. Lynam suggests that it is important for patients to be treated and conceived of as a whole person, 'sick' and 'well' (p. 174). Here, Nora is insisting on a change in the way Eliot views himself so that he will fit in day-to-day practice of the ward. Nora illustrates how activities of this ward are drawn into use to impose upon patients. Nora, in constituting Eliot as patient which affects how Eliot can view himself in the ward.

Nora expects an identity change in the way that Eliot is currently thinking about himself. Nora indicates that Eliot does not have to "dive right into this" leaving some room for him to "relax (...) and feel a little more comfortable" in such a way that Eliot is not totally deflated but, the message of attendance impends when she states "maybe not in first day or so" however, eventuality is suggested. This admission interview also exemplifies nurse Nora's efforts toward 'moving' Eliot towards a member of community and how such membership is organized by nurses. During the interview Nora did not permit Eliot to tell her about himself. Her view of him is based on what she is moving him around to see. However, Eliot is persistent with his own identity with "but that's not my problem at all" as he re-asserts his individuality against the homogeneous view of patients which Nora reveals. I suggest this resonates with Cohen's (1994) discussion of the social transformations of the self where he draws from Myerhoff's examination of "elderly Jews" to emphasize the notion of "selfhood":

> Selfhood is for them a tenacious reassertion of their individuality against the dreary homogeneity of their categorisation as elderly (p. 102).

That Eliot refuses to take on a prescribed identity, causing Nora more work than the earlier excerpt suggested, is where nurse Norman suggests a casual approach

to patient membership in community is effective. As shown by the above excerpts, identity evolves interactively, but Nora demonstrates how she can move Eliot around in ways which convey some benefits of membership for Eliot ,while at the same time revealing different interests between Nora and Eliot.

Reflecting upon identity changes made explicit above with Eliot, what emerges is that each time a nurse compels a patient to take on a 'do patient' mode, this is at the expense of this person's identity or self-identity. From the nurse's perspective she/he can't afford to have it any other way. The most efficient way of getting work done is to stop 'a person' from expressing individuality or being 'an individual' and make them be not just 'a patient', but a member in line with day-to-day practice on the ward. At this point Eliot is 'betwix and between' (Turner, 1967) but Nora is providing an image of community in order that Eliot can re-think himself and in turn, perform differently. It also follows that he can gain 'more'/value from community practices offered in day-to-day practices in this ward. In the day-to-day patients are provided with means/images to think about themselves, and terms to use which approximate what he/she is being told to do by nurses. Cohen (1994) emphasizes "the consciousness is of performance - that is, of the presentation to others of a desired image" (p. 89). Nora attempts to give Eliot markers of a possible identity. The eventuality noted above suggests that patients catch on and perform in the way nurses discipline them to act. Patients 'going along' enables and reproduces the ethos and engenders an absence of resistance. As already noted, it is patients who enrol themselves and nurses work to enable patients to see the benefits, gained only through a translation of interests.

Enmeshed in nurses' interaction with patients is the message that enrolment to community is desirable. It is not in the patients' interest to resist nurses guidance or control. The enacted strategy here seems to be an organizing of the individual as well as any sense of individuality 'out' from the activity at hand to enable a smooth functioning network of nurses and patients. If a patient instantiates themself as, or conveys the idea that they are an individual then nurses will see it as their job to turn notion of community into membership. A discussion of what happens when patients assert themselves as

a 'group' (members of community) of patients will be discussed in the next chapter. For now it is important to note that nurses organize the individual 'out' and bring patients on side for something else. Only those patients who are excluded, for whom nurses expect no change, like Ret and Bertha, are excluded as individuals (person-as-individual).

The process through which nurses accomplish such a translation is significant in day-to-day practice on the ward. Latour (1987, p. 108-121) discusses translation in a way which is analogous to the day-to-day activities of nurses interacting with patients. Latour's notion will be used to explicate the underlying control which nurses exert over patients. Latour suggests that in order to establish a smooth running unit, a functioning network, that a translation of 'interests' must occur. In the context of this ward, the analogous translation of nurse *interests* into patient *interests* is desired to sustain a functioning network on a daily basis. This enables everyone to work in the same direction so to speak. As already quoted, Head Nurse Naomi echos an imperative of a functioning network during a meeting among ward nurses:

> Naomi: And that's what I say when I talk about, "I don't care if we are all going in the wrong direction, but, I want to all go in the same direction at once cause if we don't we just undermine each other and confuse the patient".

This stresses a view that nurses organize and regulate patient action in this ward. The excerpt also underlines an 'economy' by way of patients doing the same activities which acts to minimize the work for nurses. It is precisely translation which enables nurses to accomplish day-to-day activities "in the same direction at once". Latour suggests that translation should be conducted in a way in which those accomplishing the translation ensure their own indispensability. As noted by Naomi, nurses are expected to regulate the "direction" of care activities. As previously quoted, Munro and Kernan (1993) state:

> The desired effects of translation are first, *control*, in that the work of other acts to propel one's own interest and second, *invisibility* in that one's own interests can successfully be represented in the name of others. As Latour (1987) argues, connections which follow as effects from a process of enrolment are true because they hold. This reverses the traditional order of epistemology, which assumes that things hold because they are true. Connections within networks do

> not therefore stand as 'rational', at least in the traditional epistemological sense of this term (p. 2, emphasis in original).

The "invisibility" of a socially accomplished translation of interest is important to the production and reproduction of the effect of "control". Consistent with Latour's (1987) view of actor network theory is that, here, enrolment cannot be reduced to a matter of "directions" in a dyad (patient-nurse interaction), rather it is the combined effects of practice which enable patients to see their way forward channelled by nurses. This is now discussed in relation to patient Eliot's admission interview.

Bringing a patient on side: 'there is no alternative'

Eliot's admission with nurse Nora reveals organizing practices that one nurse employs where subtle expressions and gestures are drawn on to introduce community in this ward. This example provides further empirical support concerning the social construction of aspects of 'do patient' and 'do community' as constituted by (and constituting of) so called informal aspects of day-to-day practice. Nora is talking with patient Eliot (refer back to pp. 119-120). Also present in this room is Eliot's wife Emma.

Nora conducts herself in a friendly, helpful manner and welcomes Eliot to the ward. Her performance acts as a persuasive device. Nora moves back and forth between statements like "encourage people, to attend, what we have to offer and that's each day, in the afternoon"; and "we try to encourage people, to attend, what we have to offer" and a light tone of: "I guess each day you'll be"; "I guess the nursing staff will try to talk with you and help, you know, get some of the feelings"; "maybe help you come up with some ways to help yourself feel better"; and "maybe we can help you deal with the fears and the frustrations that your going through".

The excerpt reveals an apparent 'intent' of Nora's invitational talk as well as the effect of such messages on patient Eliot. During this excerpt Nora points to two separate issues that would be good for patient Eliot and she uses strategies of persuasion to 'bring Eliot on side'. Nora questions whether Eliot is willing to take on a patient identity within this setting: "are you going to be able to stick around here for a while?". Eliot implies that 'he is not going to agree to stay' before he "know(s) what I have to do here".

I suggest this excerpt stands in contrast with nurse Leona's earlier self-evident value of community during her leading "community meeting" (p. 67). Here, Nora makes three distinguishable attempts to provide a platform for Eliot to enrol himself. Nora's attempts suggest that 'Eliot might want to' "help you come up with some ways to help yourself feel better". Secondly she draws his attention to "just fun sort (of) things" and finally Nora talks about specific activities: "each day in the afternoon"; "after you're here a couple of days"; and "people even get passes". Each of these attempts are received as faulty grounds as evinced by the effect that they have on Eliot with 'but that's not my problem' line of comments. Such manoeuvres resonate with strategies employed where translation of interests require more work (cf. Latour, 1987). In contrast to Leona during community meeting where instruction was the primary persuasive device, the flavour of persuasion here is more palatable and inviting. Yet, here also Nora points out instructions about community activities and 'encourages attendance'. Nora links being on the ward for a few days and accessing passes from the doctor which implies a bonus for being cooperative and taking on a patient identity and an identity as member of community. This places Nora (the nurse) directly between Eliot (the patient) and the doctor as an "obligatory passage" discussed by Latour (1987, p.150, p. 182, p. 245). As the obligatory passage point Nora is in a strategic position to draw together a web of associations. As noted in Chapter 1, this is a special case of an obligatory passage where there is movement along a division, a set of distinctions. Latour states that "translation reshuffles the connections between elements thus creating a new space-time " (p. 238). In this sense, re-shaping connections reveals how there is always another way to proceed with linking together associations. At this point Eliot has one way forward and is being offered a way to 'make more' of a hospital experience by way of Nora's suggestions.

Following Nora's comments about "what we do" in the ward, Eliot asserts himself saying "that's not my problem at all". However, Nora is not apparently interested in what Eliot (as a person) thinks, she illustrates a sense of imperative from another resource which she uses to direct talk with Eliot. In this strip of interaction, Eliot makes four attempts to identify what he wants, however, Nora's conduct suggests that Eliot does not know what he needs. An

alternative reading may be that Nora's manoeuvres provide Eliot a number of 'ways in'. According to Latour, translating interests requires that others (ie. patients) be shown a way that "caters to these people's [patients] explicit interests" (p. 108). It is important to pay attention to the effect that Nora's friendly invitation is having on Eliot. He is not responding to the invitation. Eliot is reading Nora's phrases differently. This implies that Eliot will not be enroled with friendly invitations by Nora. Next, Eliot's wife Emma, using a sensitive approach indicates that 'he has no where else to go'. This portrays Latour's view that a person's (Eliot) "usual way is cut off" (p. 111) and a detour is being offered as a guide for Eliot.

In relation to a transformation of identity, Eliot's wife Emma also promotes Eliot towards taking on a patient identity (person-becoming-patient) and membership to community (person-becoming-member) organized by nurses in: "I think that's to get you going with other people again". Emma's support acts to further emphasize 'what is on offer' for Eliot. I suggest Emma's work has an effect of supporting Nora in her work to persuade Eliot to take on a patient identity inside this territory. Emma follows up the effect of Nora's third plea to Eliot (pertaining to activities "each day in the afternoon" and "passes" from hospital) with "I think you have to learn to get along with other people again". This stresses Emma's view that Eliot 'must' stay (be enrolled and take on a patient identity) as 'there is no where else to go'.

Eliot is working at self-preservation while Nora and Emma are working against such a posture. Nora's actions reveal how she *pre-figures* a space for Eliot. She demonstrates displacement of Eliot's 'self' to first of all stay in hospital which Nora is not convinced that he will comply with; and second, enrol himself in community. She wants Eliot to attend and suggests that these activities will fulfil the 'identified need' (by Nora and Emma) to interact with others. I suggest both of these displacement issues reveal the difficulty that Eliot is having with the location of an authorial sense of identity/himself. Here, as previously quoted, Cohen's (1994) states that there is a "clash between a person's sense of self and the identity imposed on her or him, a conflict which is essentially about who has the *right* to define an individual's identity" (p. 178, emphasis in original). Above, Eliot's version of self no longer 'holds' within

the space of his 'family', as expressed by his wife. He has failed, by her measurement, to be sufficiently with others. He, meanwhile, has focused his energies on reclaiming him-self in a different space: that of work. However, as already noted, his constitutional authority of self no longer holds.

It is important that Eliot concedes to 'do patient'. This is underlined by the persistence of both nurse Nora and Eliot's wife Emma during the above strip of interaction. These conversational manoeuvres (as part of an array of persuasive tactics) rely on Eliot's knowledgeability, particularly over the likelihood that if he comes across as 'threatened' the process will be more difficult for him. Thus the effect on Eliot is that he must cooperate and enrol himself which is presented in the form of 'there is no alternative'. Nora tries to displace him, to position him as a patient. If he enters on this basis she can work on him but, he must first come to see himself as a patient. In relation to community which has been put to him, he can continue to resist the patient identity ('I just want a job'), however, with this identity Eliot will be excluded from membership to community. So the only way in which he will be permitted is 'when' he concedes to 'do patient'.

That an appeal for community conjures up imagined benefits for persons other than patients in this hospital ward is expressed by Emma as an identified patient's family member. She provides further legitimacy to continue work on Eliot during this admission interview. Eliot's wife Emma wants Eliot in hospital and if Nora offers community as the only way in, then community has become translated into his interests. Emma has her own reasons (evidenced in other interaction: "I can't have him at home" and "he has to stay here") and works at convincing Eliot, partially motivated by recognizing community for her benefit. In this sense, community has some value/currency for Emma. Eliot's wife, Emma supports Nora in her coaxing efforts towards involvement in community (Manning, 1992). Failing to convince Eliot, one act of persuasion used by Nora, is illustrated in 'trying to sweeten the pie' with "(t)here's also a psychiatrist"; "so she'll/ he'll talk with you and probably you know, probably assess your medications and be sure that she/he thinks those are the best ones for you". The act of drawing on the psychiatrist may be impressive in that, there is an element of 'authority' and 'orders' implicated in what nurses' do in this

ward. Alternatively, she may by virtue of this move be turning Eliot around; to seeing the importance of accepting her, Nora, as the obligatory passage. In this sense, 'better the devil you know', than dealing with unknown/unseen nurses. In this respect it is important to see that Nora can afford to be indifferent to which 'reading' Eliot may take. Each enrols him with her.

From a slightly different angle, this excerpt supports previous discussion about 'patient identity'. The efforts towards persuading Eliot to take on a patient identity are also apparent as Nora refers to "people" rather than using the term 'patients'. This tactic of Nora infers that Eliot has not yet become a patient (supported by his refusal to allow Nora to put on an identification band) and that he will be granted some time to adjust to the circumstances of being in hospital, becoming a patient, and a member of community. Alternatively, Nora's use of 'people' may be read as a conversational manoeuvre she is employing in view of Eliot resisting hospitalization. The element of 'time' underlines the provisionality of membership previously addressed (pp. 122-123) and that Eliot may be dropped from membership. However, he is being granted some time and "hopefully after you've [he has] been here a day or two" he will enrol himself in community. Here Nora displays knowledgeability over the ways in which persons construct themselves. As this varies so her interaction with potential patients can vary respectively. Nora illustrates her flexibility here through her effort to provide a different reading of day-to-day activities on this hospital ward and the accompanying persuasive devices which she employs during talk with Eliot and Emma. It appears that since she is working with someone who has not yet enrolled himself, she creates some range in her performance. These readings and posture changes of Nora in accordance with messages she is receiving from Eliot and Emma display aspects of the informal and socially constructed nature of work in this ward.

Another contrast is noteworthy when comparing Nora's interview with Eliot and Emma with community meetings where a group of patients are located. During, for example, community meeting it appears as though Leona is much more in 'control' in the group situation than Nora is with a single person. This may reveal a benefit of community meeting (a group of patients), in that it is hard for patients to voice resistance in a group. This would further

support nurses privileging a 'collective' drawing from Munro's version of 'action in a block' and Goffman's (1961) view of 'managing large blocks of people'.

Instilling discipline

The above excerpt can be discussed also in terms of discipline. Both Nora and Emma are attempting to discipline Eliot. Emma recognizes Eliot's pre-hospital behaviour as problematic and her 'lay diagnosis' of unacceptable communication patterns is legitimated by an admission to the ward. The process of admission to hospital in this sense aligns with the formal aspects of practice inside a hospital. Eliot has to be formally granted 'patient status' by a doctor. The process of admission, however, also entails a nurse conducting a standardized admission interview. As we have seen, formalizing Eliot's status as a patient is distinct from nurses informally considering Eliot a legitimate patient and one on whom they will work using community. In this section discipline is explicated as embedded in day-to-day practice in this site. Arising here in the context of conducting 'an admission interview' is an important aspect of nursing work. For nurses, it is not a matter of getting diagnoses 'correct' as the nurses suggest nor as the literature suggests (ie., Peplau 1990; Benner, 1984). A close reading of nurses' work demonstrates rather, how nurses enrol formal procedures such as an admission interview into the organizing structure of community. Such assemblages of materials tighten the network of connections which 'hold' or make day-to-day practice durable.

Discipline is employed as a knowledgeable practice by nurses, as part of the conduct of interaction with patients in the ward. Nora's language 'manoeuvres' Eliot towards docility through the notion of self-discipline. That self-discipline is effectively appealed to as a moral good is well described by patient Ginger. She explicitly states "its good for you" and "it is good" (p. 80) conveying that she is willing to use the nurse's discourse to explain her own actions. Hence, legitimating is 'taken-up by' patients: it is integrated into a patient's being and reflects a change in ontology. Positive verbalizations of discipline are volunteered by patients and become viewed as non-problematic as patients enrol themselves. This resonates with Latour's view of a translation of

interests where others already enrolled facilitate would-be-enrolled members to move in the same direction through making visible stronger connections between patient interests and nurse interests in community. Nurses mobilize patients towards 'self-disciplined' behaviour. As one of the nurses' aims, 'self-discipline' is also constituted in direct approaches to patients which nurses employ in this ward and will be examined in the next section.

From my analysis of nurses' discussions with one another and their interview accounts with me, there is some indication that nurses read performances of self-discipline (taking-on and performing cooperative behaviour) as an effect of 'learning'. However, as the previous admission interview with Eliot reveals, rather than accepting this notion is 'learning', I suggest that it is important to consider other potential explanations or conjectures such as that of patient 'discipline'. The important question to ask is 'What is being learned?' Whether such compliant actions reveal learning or disciplined conduct will be revisited later in this chapter once further aspects of the selection process have been explored in terms of nurses' "assessment" of membership to community. As shown, in Eliot's case, he was informed about community and has experienced expected changes in his performance to that of a patient. However, nurses draw from other interaction to help constitute patient membership to community.

Selecting patients for 'group' membership

There is one particular community activity, *group* for which nurses have a special selection process for patients. I will present how such selection occurs and then present some excerpts from group. Nurses employ a selection process to distinguish among members of community and other patients (patient identity status). This is reflected in the words nurses use to describe the skills of members. One nurse describes patients selected for members of group saying that: "they are high functioning patients". It is commonplace for nurses to use this phrase in association with that which is identified by nurses as "afternoon group" and also called "group therapy". Nurses selection of patients for this group is partially based/legitimated on pre-defined criteria which are relayed to group members before they attend their first group session. One of

two nurses who regularly conduct this group session approach patients who are viewed as suitable and invite these patients to attend. An extension of the persuasion devices already discussed are those which nurses utilize in their approach to patients for this particular group. Attendance at this particular group evinces a hierarchical notion of community membership. Expected conduct of patients during group is identified for prospective members and is also written on a black board where this particular group session is held. Nurses claim that this group process "gives [patients] the opportunity to" do the following:

> 1) learn how others perceive and react to us by asking for feedback ie do I talk too much, too little, interrupt, am I showing interest actively listening etc.
>
> 2) Practice new ways of relating in a safer environment
>
> ie - sharing how I really think / feel and asking others for feedback on this.
>
> - practicing saying "No" and observing how others react.
>
> 3) Supporting others by sharing our thoughts and feelings honestly when asked for feedback. Giving others the benefit of our experience.

These directives are read aloud (by members attending this group) as new members join this activity. Nurse Tina claims that patients who are perceived to be able to conduct themselves in the above manner, skilled interlocutors, are selected for this activity (see pp. 47 and 112 for discussion of 'suitability').

For patients as well as nurses, this is a special group. The special nature of this group is underscored by the use of a consent form which patients sign prior to attending this group. Confidentiality among group members is legitimated by a group consent form which is one further way of sealing off 'membership'. Confidentiality of members does not apply to nurses and patients in the same ways. Patients are not to talk with other members outside of group about issues raised during group, referred to by nurses as "group issues". However, nurses talk with other nurses about 'group issues' so confidentiality is only partially upheld by nurses. Nurses view such difference 'as normal' practice. Hence, nurses have special privileges.

The particular ways which nurses select patients for attendance indicates how it is a 'special' type of activity for nurses. According to the Head Nurse, two nurses are specifically assigned to "run afternoon group" based upon their competency to perform skills of "group therapy". Other nurses support the skill level of these nurses to "do group" during interview accounts with me. However, nurses who make these judgements have not necessarily seen the two nurses conducting 'group' (ie. Alison, p. 47). In some cases the 'goings on' between nurses conducting this group session and attending patients are speculated upon by other nurses. There is no direct report among nurses about group, but, occasional anecdotes are exchanged in kardex. Tina and Nora (nurses who conduct group) write up daily anecdotes in patient charts such as: "(p)articipated in group. Opening up with members of the group". These anecdotes are sometimes provided as Tina and Nora deem relevant during nurse kardex sessions (discussion among nurses which is examined in Chapter 7). Here, knowledge as power, is important where these group leaders have considerable influence over other nurses; this is especially so given the 'special' nature of this particular group.

Prior to a group session with patients, two nurses who conduct group (Tina and Nora) hold a meeting referred to as "pre-group" where they discuss their plans for group (see Table 1, p. 51). Following group with patients, "post-group" is held, again with only the two nurses (and infrequently others who may observe group such as myself) to discuss their views of what transpired during group and to document such anecdotes in each attending patient's chart. Hence, nurses who conduct this community activity spend a considerable amount of time discussing group activity both before and after the actual session when patients are present. These meetings are geographically and socially separate from other nurses in another enclosed room to minimize disruption. The special position for nurses conducting group is elevated by and underscores the presumed skills (competencies) of those nurses conducting "group". In this respect, there is a hierarchy among nurses on the ward.

Nurses exercise control of community in a number of ways. For example, nurses manipulate patient belonging to organized community activities. In the case of "afternoon group" nurses facilitate patient belonging in

ways which enable performances of community. Sometimes nurses base their manipulation of patient belonging to group on what nurses perceive as a "common" thread amongst members of community. What emerges is that, nurses conducting group manipulate group membership based on pre-established content of group such as "grief" and "family issues". In turn, patients who are viewed by nurses to be able to talk about "grief" attend group, while other members of community will not be invited to attend group. In this sense there may be some variation in the theme used by nurses to stabilize group membership. However, in practice a minimal number of issues are pre-arranged by the nurses and the index of themes permitted by nurses is limited. In this respect, an aspect of stability is maintained or controlled by nurses, in relation to acceptable themes, on a week-to-week basis.

Nurses stabilize features of group in ways which contribute to the enactment of nurses' conception of this activity. For example, group occurs five days a week; two nurses chair this session; pre and post-group sessions are conducted by two nurses chairing group; and the number of patients may range but, "at least three and no more than eight patients attend". If there are less than three 'suitable' members, there is no group on that particular day or series of days. That group is sometimes dropped acts to support one way that nurses privilege or prefer to work with a collective of patients rather than patients as individuals. Hence, in group and during community meetings nurses accomplish similar ends; the gathering provides a legitimate forum and face-to-face contacts with patients enable nurses to penetrate patient spaces to 'move' them around. Within face-to-face interaction, nurses use this work space to train patients to 'do community'.

In contrast to nurses surveying, chatting and talking amongst patients during morning activities, nurses in group actively 'move' the discussion along. Whereas in say the provision of medications nurse surveillance practices were 'subtle' or concealed, in the context of this region of work (group), nurses firmly control the direction of talk. For instance, in the following excerpt, Tina and Nora facilitate patient turn-taking, catharsis and they re-frame patients' talk. Similar to other community activities, attendance or non-attendance of patients is important. In some cases, simple attendance is enough

for nurses to suggest that patients are participating in group. At other times nurses push patients to talk and address other members of group.

Members 'do community' in group

The following excerpt represents the typical manner in which group is conducted. At the beginning of group Nora begins with a question to members after everyone is seated in a circular formation of chairs:

Nora: So . . how is everyone today?

Patsy: Here (nods and laughs, others join in laughter).

Tina: That sounded a little bit tenuous.

Nora: How's your day (turns to her right) been going Ginger?

Ginger: (ha, ha) Monday's over so

Nora: You

Ginger: . . . Yeah.

Patsy: . . . We agreed, we went with her this morning.

Nora: Your days are going . .

Ginger: Yeah, my days are going great, they are giving me [missed couple of words from audio-tape].

Nora: Do you want to maybe ask someone else (motions with a pen she is holding in her hand. Black book open, lying on her lap.)?

Ginger: How are you doing today Michael?

Michael: I'm doing just fine. I'm doing just great.

Ginger: How are you doing Oliver?

Oliver: Ohh, I guess, fine, I guess (laughs, pinches nose, laughs, head down) I'm doing great actually (smiles and looks across to Ginger) great.

Here nurses display and facilitate aspects of community work during "group therapy". For example, Nora asks Ginger about herself and then asks Ginger to inquire about another group member. In this way, Nora successfully

accomplishes a demonstration of community for this group of patients in a two-step process. First, she asks Ginger "how's your day been going?" which serves to 'act out' being social directly with Ginger. Second, by asking Ginger to then ask someone else in the room 'how they are doing' produces a performance of one way a member interacts with another member. Such a display enables, through display and instruction, the work nurses' conduct to initiate interaction among members. A minimal amount of work is required by nurses and this contrasts with Ginger who does the work once she is aware of 'how' Nora wishes community to be performed. Nora suggests that Ginger ask someone else which leads Ginger to ask two other patients who had not spoken until this point in the session. Thus, Nora's simple instructions prompt Ginger to 'do community' and involve two remaining patients in the discussion. This emulation appears to have a rippling effect which involves more and more patients, without specific instruction from nurses. Using an analogy once the stone is dropped, a nurse's message, ripples are effected, and patients run with it. Here similar to patients picking up on "one-to-ones" instead of say talk with a nurse, Ginger exemplifies the disciplining effects of discourse which will be revisited in Chapter 6.

The above excerpt also illustrates patients' giddy behaviour. Such patient discomfort may be related to the fact that they have been interacting with one another since their waking hours earlier this day. Nora's line of questioning may be more appropriate for getting persons who are not familiar with one another to interact, but, seems inappropriate for these members who have been physically present with one another for a lengthy period of time. I suggest that these nurses are interested in 'knowing about the members of this group' but the example displays an artificiality and a restricting method of nurses inquiring about these members. This cross-links with the theme of Chapter 7, in that, these nurses have not been interacting with patients (what nurses do when they are by themselves is the focus of Chapter 7).

Additionally, such instructions from nurses suggest nurses view patients as disrupted to the point that they require assistance from nurses in order to act appropriately (exchange social pleasantries with others). In other words, the received view of nurses, based on their treatment of patients in group, is that

patients require instructions for indulging in day-to-day conversation with other patients. From the patients' perspective such instructions may raise questions for them in relation to their own identities and their knowledge of how to interact with others. Above, conversational moves of nurses represent skills of competency and for-all-practical-purposes (Garfinkel, 1967) act as displays for patients, performances through which members are instructed how to conduct themselves (refer back to discussion on p. 27).

In this sense group is a special activity. In an excerpt analyzed more closely in the next chapter, nurse Leona informs community members that group occurs in a "special room" (p. 162). Movement to a different geographical space is also a movement towards a community space that has implications for what constitutes performances of nurses and patients. Although it appears to the nurses that patients may not be knowledgeable in the specific setting of the ward, they will 'learn' through group to read the situation as nurses provide the missing instructions to enable patients to display themselves as informed members of community. Once patients are informed that, for example, today's group is about grief, patients can conduct themselves is the ways in which they perceive nurses want. As previously noted, Tina and Nora, during 'pre-group' or the previous day's 'post-group' decide on the theme for group. I now turn to examine one exercise employed by nurses during group.

"Imaginary gift" exchange: an example of a consumer culture

One exercise that nurses employ during group with patients reveals a number of aspects of instruction as well as making visible how nurses view the relationship between themselves and patients as members of community on this ward. Nora refers to this exercise as an "imaginary gift giving to Tina". An 'imaginary gift' is given to Tina as she will be away from group on a planned summer holiday. Strathern (1990a) states:

> A consumer culture is a culture, one might say, of personalisation. And gift-giving seems to us a highly personalised form of transaction. After all, it was the person in the gift that attracted anthropological attention in the first place (p. 6).

I would like to relate Strathern's point over 'personalization' to the way in which a gift-transaction occurs in group. In order to explicate such an exchange

several excerpts are presented sequentially to illustrate how such a transaction was drawn on and the respective responses of patients and nurses at the time of its use. The day prior to the 'imaginary gift giving' nurse Nora requests that members of group are to "think of an imaginary gift to give Tina". Nora explains:

> Nora: Ah, Tina is going away on holidays and none of you will see her. Friday ... is the last time and you will all be discharged before she gets back. So we thought it would be a good way of terminating with her and saying good-bye. . . . Terminating can be real tough . . . and . . . she's been here with you since you all came. It's important, like you know, gifts don't always have to be ah ... something firm, something you can hold and this will be a chance to come up with something that you think she would like and you can leave it with her.

Here, Nora suggests that an "imaginary gift" be presented to Tina on the following day. This transcript indicates that Nora and Tina have decided that this would be "a good way" to deal with issues of "terminating and saying good-bye". Nora suggests that because Tina has been present in group since all of these members were admitted that this exercise would act as a parting gift/strategy of detachment.

Nora suggests that gifts do not necessarily have to be of a material form but that it is "important" to 'leave something with Tina'. These members are being asked to provide an imaginary gift which is regarded as an extension of these members insofar as gifts carry the expression of sentiments about the relationship between members of this group and Tina. I suggest that Nora is instructing these members to enter into this imaginary gift exercise with a sincere spirit. The pre-determined exercise implies also that, there is "an obligation to receive which cannot be reduced to the enactment of any one particular exchange itself" (Strathern, pp. 21-22). In Strathern's view, Tina would be obliged to accept patient gifts. However, it is important to recall that nurses pre-arranged such an exchange which emphasizes that nurses are obliged to receive those gifts presented by patients.

On the following day in group, the typical "ask so and so how they are doing" re-commences during which time patients were joking and laughing with one another. Nora interjects, punctuating the exercise with "Does anybody, feel like doing some work? (...) Do you want to start that now?" as she

is looking at patient Michael. Nora is identifying the imaginary gift giving exercise as "work" and infers that it ought to be taken seriously by these members. Each member contributes an imaginary gift and Tina makes a response following the receipt of these imaginary gifts. The following excerpt includes members expressions of imaginary gifts which are in turn responded to by Tina:

> Oonaugh: I would just give her a lounger so that she could relax because she makes us so relaxed in here.
>
> Tina: Thank you. That's very nice. (speeded voice then slows) I'm happy to think that you feel relaxed in here and I'm happy to think that I'm going to be lounging.
>
> Oliver: I would have to say something along a thinking cap line, your, laughing and fun type of cap because you tend to be serious, you are a serious type of person and you have to laugh. A cap or something.
>
> Tina: A laughing cap. That sounds like fun. (pause) Thank you for the feedback (speeded voice during thank you for the feedback), that's something, I think that we look for as much as we try to encourage you to, it is very interesting to know how other people see us, and maybe sometimes I do appear to be ultimately very serious, but I think in other contexts I am very serious about having fun too. So, I would like a laughing cap, I would probably get lots of use out of it. Thank you for giving me the feedback and the laughing cap.

Patient Oonaugh identifies a "lounger [chair] so that she [Tina] could relax" which Oonaugh links to aspects of her relationship with Tina in group with relaxation in group. This reflects Strathern's view of 'gift-giving' where the gift is an indigenous symbol through which the type of interpersonal relationship is made visible: making present. Here, figures of persons-as-members appear with particular relations/associations. Tina thanks Oonaugh for what she implies is an appropriate and welcomed gift.

In contrast, patient Oliver's imaginary gift is a "laughing cap" because Tina is "a serious type of person" and the implication is that Tina is too serious. Tina's response to Oliver is also one of thanks, and she states that she finds it "interesting to know how other people see" her. However, she continues on and qualifies the seriousness that Oliver identifies by indicating that "I do appear to be ultimately very serious, but I think in other contexts I am very serious about having fun too". Tina picks up on Oliver's imaginary gift as being

wrapped as "feedback." I suggest this also reveals that this gift is not an off-handed imaginary gift, Oliver has been thoughtful about his imaginary gift which underscores aspects of members conduct in group and illustrates what Strathern suggests "carry identity" of the giver and receiver. In particular, practicing "honesty when asked for feedback" is identified as a group rule (p. 132). This resonates with Strathern (1990a) when she states:

> Gifts are not free-standing: they have value because they are attached to one social source ('father') in being destined for another ('child'), and whether they originate in labour or in other transactions, carry identity (p. 19).

The imaginary gifts these patients provide reflect aspects of the way in which they formulate Tina's identity and their own identity. Each of the six attending patients provide an imaginary gift for Tina in turn around their circular formation. Following this contribution by all group members Nora asks:

> Nora: So how does that feel, (hands moving in front separated to right and left) for the group, the termination, I guess what it would be, with Tina leaving? It sort of seems . . .?
>
> Ginger: Well, I'd also like to see her be here, but I also know,what it's like to have a holiday (laughs), so, I think it is good for her.
>
> Patsy: I think its been good for us too because you have helped us relate as individuals and as a group and its something that we've carried outside this room and ah, at meal times, and games, and we've always had the advantage of learning from one another.
>
> Tina: I feel in some ways that maybe what's happening is maybe, relates to what you've talked about as your tasks to stay together, because we don't always have groups that stay together for any length of time, just the nature of an in-patient ward, and this group is quite solid, and so, from my point of view I am quite interested to know how what your progression is and what you gain out of group, in say the week to come that I'm not going to be here, so it's a little difficult to let go, but I also have the faith that you will do it, you don't need me here (hand on chest) to do it, but its' that little bit of mixed feeling. Sort of like you Patsy with your children, you have to let them go, they have the ability to fly, but it still would be nice to . .
>
> Patsy: . . . I know that feeling (ha, ha).

Members of this group display aspects of community in their use of language: "you have helped us relate as individuals and as a group and its something that we've carried outside this room"; and "the advantage of learning from one

another". Such comments imply a sense of 'value' for these patients through particular relations with other members. It follows, that these aspects of community have provided person-as-members with 'more', a prosthetic extension. Tina identifies the group task as their "task to stay together" which elucidates 'attachment' as important in the face of not being able to "stay together" for any length of time. This makes views such as Strathern's (1991) explicit, in that staying together marks a type of connection between these persons-as members-of-community. Finally, Tina makes Strathern's analogy with family apparent as she associates her own (Tina's) view of 'having to let go' with Patsy, a group member. In another way this analogy exemplifies a relation to 'community-family' metaphor which Fernandez (1986) identifies as "syllogisms of association" (p. 125). For example, 'I Tina am to you patients, as Patsy is to her children'. The association set up here is that patients are the nurses' children where detachment, not being able to "stay together", is 'normal'.

This excerpt also illustrates that members of this group have some difficulty perceiving that a holiday for nurses, can be read as other than a 'normal activity'. Immediately following the above excerpt, members of this group appear stuck and did not appear to have anything else to contribute, nor able to express any further appreciation to Tina as there was a long silence. Next, Tina moves the discussion to "saying good-bye's in general" which sustains discussion for another few minutes. Tina then takes each member in turn and comments about them in the following ways:

> Tina: Thank you very much. . . . . I feel overwhelmed. And I didn't bring any presents for you but I have some wishes that I would like to leave you with. Uhm, Michael my wish for you is that you be able to use the group, and I see you doing that already. Use the group to relate to people in a way of what you think and what you feel rather than always external. I see you being very interested in people's thoughts and feelings for those in this room, and I hope realize that other people are interested in your thoughts and feelings too. And may that sort of, so you can expand your world. . . . And (looks to Oonaugh) Oonaugh.
>
> [. . .] My wish for you is that, especially now that I see you feeling better, I see you interacting more, initiating more which was an issue for you when you came into group, is that you will be able to use, the skills that you have learned in group, and take them with you, and work towards independence, so that that transition comes

> smoothly and that I think maybe too, the group can help you realize that being alone isn't always, threatening. It can be a time for self discovery so that you can learn what an interesting person you really are. So that you can face it with less fear. [. . .]
>
> Uhm. (pause) Ginger, I working with you, I think I have seen some real changes in a short period of time, and the one that sort of stands out is, I guess the one that initially your focus was sort of outside the group, focused on what was happening around you and reacting to them rather than acting from you (motions inside with hands) according to how you want to be, my perception is that that has changed quite a bit so my wish for you is that you're able to continue that because I think you have lots to give I sense that you have sort of an expectation, or, uhm, that you know the person you want to be and you're working towards that [. . .]
>
> My wish for you is that group will help you to trust your own goodness, and in doing that, that you will be able to, ah, make it easier to let go, or to change, because I think relationships always have a waxing and a waning, like the moon, there are times when we feel very close to people and there are times when we feel more distant and that's in almost any relationship, and if you can, if you can use the experience in group to feel that you have given something worthwhile to your relationships that you will be able to accept that, that without feelings of guilt, and flow along more smoothly. And I see you doing that, I see you moving, my sense is that you're feeling better about yourself [. . .]

I suggest that Tina's speech invokes aspects of a 'Benediction' in that the above exchanges convey Tina's blessing to these members of group marking the end of her time with them. But she offers more than blessings. Tina says "Michael my wish for you is that you be able to use the group, and I see you doing that already" and to Oonaugh, Tina says "(m)y wish for you is that, especially now that I see you feeling better, I see you interacting more, initiating more which was an issue for you when you came into group". Her talk is not only ceremonial but, is conferred with approval of their success in making a transition from isolation towards an identity that springs from being in group enabled only through becoming a member of community. This emphasizes a previous comment in that, membership has its privileges. Tina suggests that a hospitalization transforms individuals into members of this group, a transition from those who are denying their problems to those who are insightful, truthful and honest about their problems within the confines of a stable and secure setting of the ward. For example, she uses words such as: "relate to people"; 'draw from internal rather than external'; she emphasizes "thoughts and feelings"; "other people are interested in your thoughts and feelings too"; "I

see you interacting more, initiating more"; "skills that you have learned in group, and take them with you, and work towards independence"; "self discovery"; "trust your own goodness"; "relationships always have a waxing and a waning"; "close"; "distant"; and "relationships". This underscores, I suggest, how through performing aspects of community persons-as-patients become 'whole'. Belonging is also a matter of letting go and Tina is instantiating how she can 'let go'.

This exercise is an instance of the persuasive nature of the relationship nurses have with members of this group. It is important to problematize the imaginary gift giving to Tina in exchange for "wishes". The wishes which Tina provides during this group were pre-scripted by Nora and Tina during "pre-group" on this particular day. This is apparent in the generic types of wishes that Tina displays. In this way the 'genuine' imaginary gifts from group members stand in contrast to the non-personalized wishes which Tina delivers. Tina has one wish for everyone: a lecture on the necessity of change and accepting it. In a discussion focusing on consumer culture, Ferguson (1992) suggests "all wishes" are "insincere and childish" with a "dream" like quality (p. 31). As already noted, Tina and Nora do not leave it to spontaneity and inter-subjective moments of talk with patients (they organized themselves in pre-group). Tina does however, personalize her wishes by identifying each member of the group by name (included above are Michael, Oonaugh, Ginger). The last wish is for the "group" which suggests that Tina see's members of this group as a collective.

Tina's wishes convey her prescribed sentiments about members of this group and she makes specific relationships visible. Tina accomplishes a social distance using a 'special' exercise with members of this group. Cheal (1988) suggests that present-giving among friends and relatives in suburban Canada indicates community membership and the reproduction of social status as well as relations of intimacy. In the above case, Tina reproduces the status of members of one of belonging to group and her own status as a ceremonial leader. She also has the last word. Members of this group are left to perform an aspect of community although contrived by nurses. Nurses claim that emotively charged experiences occur within community where "caring and

sharing" are identified as "good to see" by nurses. It is suggested this 'staged performance', as evinced by preparation on nurses part, is about reconstituting nurses status in relation to members of this group. More importantly, Tina's messages embody 'expertise' which distance her from members of this group. Their hierarchical orientation is made explicit by nurses when they legitimate what they do as being what a patient will 'need' when they return to the wider community outside hospital.

Nurses' performances of expertise: effects of detachment

Patients and nurses treat nurses' actions as 'good' or beneficial. One aspect of nurses' conduct relates to competencies. As has been discussed, patients obtain membership to community through the process of enrolment. Nurses work to translate patient interests to one in the same with their own interests. In this sense, nurses have a captive audience; patients have the desire to get better or heal. Illustrations of enrolment have been discussed drawing from patients (Ginger and Eliot). Combined with patient desire to get better and heal, nurses influence this process when they come in contact with patients. For-all-practical-purposes (Garfinkel, 1967) patients and nurses take-for-granted that nurses are the 'experts'. Nurses' authoritarian actions (and segregated practices to be examined in Chapter 7) reinforce such a stance. Although dominating aspects of the nurses' role are bracketed, patients are impelled instead to perceive nurses as experts and to constitute their social relationships with nurses on the basis that nurses are expert members of Bestcare.

Expertise can not be assumed in an examination of practice and is not assumed in this particular study. As identified in earlier chapters, assumptions lead to unreflective practices and incomplete examinations. As previously noted, I have suggested, assumptions are synonymous to Latour (1987) and Frankenberg's (1966) depiction of a 'black box', they are matters which can be opened and examined. However, these assumptions are not questioned by nurses and they carry on conducting day-to-day practice as they have done previously. It also follows, nurses are assumed by patients and one another to have expert knowledge and authority within this ward. In this way, 'by good authority', patients receive community, membership and the means through

which nurses enrol patients to be based on expert knowledge. This expertise invests, somewhat recursively, nurses with authority to act as they do. This recursive production of expertise is aided and abetted by the relative absence of doctors for the ward.

Nurses enact their expertise through creating social and geographic distance from patients. For example, the standardization and routines involved in day-to-day activities between nurses and patients produces a boundary between patients and nurses inside the ward. Both nurses and patients express knowledgeability about their respective positions in relation to others. The strength of this distinction (between who is a nurse and who is a patient) is apparent in an interview account of what happens during the day inside this ward. Patient Rory says:

> Rory: No TV's in room, they [nurses] want everybody to mingle ... they [nurses] just more or less, they [nurses] never said nothing but I asked the doctor one time. Today was baking I don't like baking ... crafts and walks out in the parks and they [nurses] take you down there (...)

Within this excerpt Rory employs the use of the term 'they' (nurses) on four occasions: "they want everybody"; "they just more or less"; "they never said nothing" and "they take you down there". He marks a distinction between nurses and patients and recognizes a particular basis upon which such a discrimination is made. This reveals that Rory distinguishes nurses from patients in daily activities. Nurses direct and patients follow. Taking another step, nurses detach themselves from patients and patients attach themselves to one another as members-of-community.

Another example may be helpful. Defining a patient as a patient is also constituted during nurses daily contacts with patients. Such sign-posting is suggestive in that, the delivery and receipt of medication is a routine activity which illustrates authority of one person in relation to another. The permissible locations for nurses and patients within the geographical boundary of the ward illuminates yet another way in which the position and identity of nurses and patients are produced and reproduced in day-to-day practice. Such positioning is practiced regularly between nurses and patients. Patients know

who they are and they know who nurses are. Such a finding resonates with Goffman's (1953) discussion of Dixon community members.

Further ways in which nurses' positions are socially accomplished as distinct from the position of patients within this site is that nurses do not identify themselves as members of community. Instead nurses see their position as one of organizing and regulating. Such 'detachment' enables nurses to talk about patients and patient performances from a distance which is the way they constitute their relation to patients in community activities. I have shown the creation of distance in the imaginary gift giving in the previous section of this chapter. This 'detachment' is also apparent during nurses' discussions with one another when Tina provides some anecdotes from group stating:

> Tina: I get a sense that she is trying to implicate us [nurses] in what she should be responsible for.

Tina distinguishes between "us" and "them" to delineate nurses and patients respectively. This distance supports a detachment evinced in community meeting which nurse Leona chairs. Another example is provided by Tina's "wish-giving" versus patients "gift-giving". In other cases, nurses accomplish this distinction socially in day-to-day practice where nurses 'survey' (observe) patients during community activities and congregate together to relay anecdotes to one another.

Nurses fulfil an onlooker (observer) or spectator position in relation to community activities for patients. Nurses do not consider nor constitute themselves as members of community they construct. Foucault (1977) discusses the term spectacle and suggests that society is not run by spectacle any more rather, society is signaled through surveillance. Following Foucault (1977), in this empirical setting, nurses are not merely spectating they are deploying surveillance practices to accomplish something else. I suggest that nurses are looking at patients with a particular 'gaze', addressed by Foucault (1973), which informs nurses in particular ways about particular aspects of day-to-day practice. During nurses' discussions with one another they employ segregation tactics: while they are within the sight of patients on the ward they are isolated in a room. That nurses are visible to patients and patients to nurses makes visible the distinct work spaces for nurses and patients in this ward. One further way

in which nurses display competence and authority is in relation to their treatment of patients who are reluctant to enrol themselves in community and patients who are not invited to join in activities. In such cases, nurses take disciplinary action instantiating the threat of sanctions to which I now turn.

"Just won't move": threat of sanctions

The third activity of care to be discussed is how nurses deploy strategies of domination through the threat of sanctions. Both patients and nurses are knowledgeable of and constitute their respective postures in day-to-day interaction (nurse-patient). Similarly, in relation to domination both nurses and patients constitute those who dominate and those who are dominated over.

The following excerpt captures what is openly recognized among nurses as their approach to patients. Nurses act to distance (detach) and control patients in this ward. Nurse Zana make this point during an interview with me:

> Zana: (...) usually we don't have a real big problem with them when we encourage them, some people are complying other people aren't as far as wanting to get involved with activities... but we like it to be known that if they aren't willing to that, you know this is part of the treatment if they don't uh want to socialize or become involved with the ward and the activities that are going on in the ward that they are basically refusing treatment and sometimes what can happen, the doctor will discharge them because that is a part of treatment and they are not serving the purpose of why they are here. So quite often usually it is not a problem, the patients usually comply they know they've come here for a reason.

This excerpt reveals Zana drawing out that "we like it to be known" and she goes on without hesitation to include "what can happen (...) the doctor will discharge them" if patients fail to "comply" with what Zana refers to as "encouragement". I suggest that such encouragement more accurately portrays a strategy of 'domination' and as such requires problematization. Nevertheless, other nurses also identified this overt strategy during interviews. Nurses 'openly sanction' and relay their approaches to patients who are not cooperating with day-to-day practice. In discussions with one another, nurses state "he/she may as well get out because we're not doing anything for them". Nurses tell patients that "I expect you to attend" and inform them that the consequences of

not cooperating are discharge in: "you will be discharged". Within such scenarios nurses employ the threat of sanctions with patients.

As persuasive strategies, Lyotard's (1979; 1984) discussions of language games and 'moves' helps to explain how interaction can be examined in terms of 'vested interests'. Persons engaged in interaction exemplify a back and forth movement of speech turns as they develop a common language (in Gadamer's terms) or cross-check understandings. In Lyotard's view, such back and forth movement constitutes 'moves' and 'countermoves'. Lyotard claims that 'moves' are employed to exercise leverage over others and in this way, language disadvantages the other. In this respect, Lyotard (1984) addresses displacement of the other. He states:

> Each language partner, when a "move" pertaining to him is made, undergoes a "displacement," an alteration of some kind that affects him not only in his capacity as addressee and referent, but also as sender (Lyotard, 1984, p. 16).

For Lyotard, 'countermoves' are associated with a person's ability to make 'novel' moves out of, say the ambiguity of a term. Moreover, when a term such as community is employed, given the ambiguity which it engenders (Cohen, 1985), it is expected to reveal a multiplicity of readings and behaviours in the day-to-day. Here, cultural performances accentuate the extent to which an expression of community is productive in constituting different versions of everyday community practices.

From the patients' perspective strategies or approaches such as the threat of sanctions by nurses are persuasive. Strategies of domination act to sustain respective postures of 'a nurse' (expert) and 'a patient' which are recursively demonstrated in nurses day-to-day approaches to patients. Patients learn to posture themselves when approaching nurses on a daily basis. It can be said that patients allow nurses to dominate them in interaction. This is what Goffman describes when he talks about 'giving in to the domination of the other' or when people "give themselves up to each other" (1963, p. 166). However, as previously indicated, the act of complying/cooperating also reveals the knowledgeabilities underlying patients' performances. Different expressions indicating reasons why patients' think they should not have to become part of the group (ie. Eliot "just wants a job") which arise during

interaction represent resistance to nurses. The persuasive strategy of nurses dominating patients occurs in variant interaction. In essence such examples demonstrate slightly different ways of accomplishing patient cooperation. What emerges is that, the employment of such strategies effects self-discipline of patients.

By nurses employing the threat of sanctions patients are 'moved' to 'do patient', that is, be cooperative. Here 'power over' a patient is the persuasive tactic employed. In some cases the use of domination to attain cooperation and enrolment from patients arises from nurses pointing to another authoritative figure, such as a doctor. In this sense what is enacted may be identified as a threat. The authoritative figure does not need to be physically present but such a member is simply identified by another member (ie. nurse) from the ward. For example, nurse Alison says during a discussion with other nurses that "I just encourage him to take it (a medication) and tell him that the doctor ordered it". In such a case, a patient's reluctance is counteracted when Alison draws on an authoritative figure, the doctor, and the patient is persuaded. This suggests that a patient is over-powered by the nurse's strategy and conforms to what the nurse wants, that is for the patient to take the medication.

In other cases nurses view strategies of domination as a 'skill' which is voluntarily provided to me in the form of a 'standing joke' amongst nurses in this ward. Nurse Tina identifies this 'skill' and suggests it is desirable for day-to-day interaction with patients. During the first interview with me Tina provides the following account of such an approach to patients:

> Tina: (...) I mean I think the personality of each has to sort of be taken into consideration. Uhm, you know we have some people here, you know its a joke, if you want anybody to get mad, assign a certain nurse to them because they are just really good at getting some of that affect out of people, so its like you know I think they need to learn how to get angry here, lets (laughs) give it to so and so.
>
> Maxine: What might that person do to get them angry?
>
> Tina: I don't know, I am still in the process of trying to learn that (laughs). But some people are much better at it. They are uhm, you know and I know patients are like, "I don't want her for a nurse, she irritates me". But then sometimes it is a gain to see how somebody irritates them. Jennifer is really good at irritating people, I think Jody is pretty good at irritating people, and Hillary, ... Amy ... and Leslie are really good at precipitating a crises.

Maxine: Precipitating a crisis?

Tina: Uhm, escalating, sometimes with somebody who just won't move, just sort of escalating something to the point where they move one way or the other.

Maxine: Is that something that is discussed openly?

Tina: Oh yeah, uh hum. That's quite a joke with Jennifer because she has been here for quite a long time because she's the best there is at irritating people. She is very pragmatic and very straight forward and, to patients with certain dynamics that's extremely irritating.

Tina suggests that some nurses are more skilled at some approaches and also that some approaches such as the 'standing joke' are valued by nurses. I suggest Tina underlines a currency for such action, an economic value, as "sometimes it is a gain". She indicates that it is 'just really good to get some of that affect (emotion) as though nurses need to 'dig' as a result of "affect" being concealed ("where they move one way or the other"). Tina goes on to suggest that such concealment results in nurses' action to "precipitate a crises" for a patient because "sometimes it is a gain to see how somebody irritates them". In these ways, what nurses suggest is a skill enables them to facilitate patient cooperation and enrolment to community or with patients who have been excluded from community (patients-as-individuals). When surveillance does not provide the desired discipline and translation of interests from nurses to patients has failed, nurses draw from strategies of domination in their approaches with patients. This resonates with Munro and Kernan's view: when translation fails, other overt, that is, 'visible', means of moving patients towards collective action emerge in day-to-day interaction.

Examples of threats of sanctions reveal how nurses are discursively unpreoccupied about their approaches to patients. Nurses are not concerned with the implications of such dominating approaches with patients. From the nurses' perspectives above, strategies of domination are viewed as beneficial in that they enable day-to-day work of nurses. I suggest that Tina removes the markers of what she is describing by glossing over nurses action (ie. privileging an outcome rather than how it is accomplished). This enables her to displace coercion tactics and threats, in order to legitimate the accomplishment of "movement" from patients. I also suggest that this is one way that nurses

overlook their coercive tactics with patients while they remain focused on something else. In this case, Tina states the patient "just won't move" so they are provoked to "the point where they move one way or the other". This places the 'activity of care' being discussed here, threats of sanctions, into more palatable terms: domination is understood in this setting as therapeutic. Peplau (1962; 1988/1990) also suggests such tactics of domination are legitimate approaches with patients. In the wake of issues of patient participation, strategies of domination shed some light onto how consent is manufactured in day-to-day practice of the hospital ward. Expressions of "escalating", "precipitating a crises", "getting some of that affect out of people" and "mov(ing) one way or the other" are considered by nurses to be 'activities of care'. In the next chapter I examine how nurses sustain the practice of community with those views which patients appear to understand.

There is a distinction between nurse and patient work in a translation of interests. In order to make a translation of interest relevant and durable Latour (1987) identifies two aspects to translation. First "to enrol others so that they participate in the construction" of day-to-day practice and second, "to control their behaviour in order to make their actions predictable" in those same daily organizings (p. 108). As shown, nurses persuade patients to enrol themselves in community performances. Importantly, patients do not actively enrol themselves. Instead, nurses work to move patient interests towards their own interests (in the same direction) while constituting an indispensibility of nurses. This crucial difference, reveals Latour's position where networks of relations are brought into being by multiple action of those constituting relations. That translation of interests works, underscores the effectiveness of nurses interaction with patients. Here I am anticipating patient work which is discussed on pp. 173-174. However, it is also important to note that, following Latour, negotiations are required but nurses suggest that "I [nurse] want what you [patient] want" (p. 108). Such forums are the locales in which patients are 'offered' a way forward towards their own healing.

Chapter 6

'Testing . . . Testing . . . community in practice'

Introduction

In contrast to previous chapters where nurses work to keep day-to-day activities in place by standardizing the provision of care to patients, this chapter discusses how community as deployed by nurses acts to undermine everyday notions of community which they mobilize. However, a play of both 'stability' and 'ambiguity', which community provides, facilitates nurses work with patients to sustain community. I explore how community which nurses espouse and that picked-up by patients illustrates a clash in practice. Some instances of these clashes are provided in order to reveal how community is recursively produced despite conflicts in practice and effects which nurse-patient interaction has on patients with others. Community as a practice is durable, however, negotiations are also involved in day-to-day interaction between nurses and patients. More specifically, I will examine daily practice and elucidate the movement generated in a way that distinguishes nurses' expressions and use of community, from patients' expressions and use of community. Nurses mobilize both aspects of stability and ambiguity to keep community in play as a legitimating device for nurses work with patients. That contradictions emerge in practice helps to explicate how community as a device is central to nurses' work. Situations arise when community in practice is problematic for patients and they attempt to come to terms with what community represents (means) during interaction with nurses. In these cases patients make efforts to understand what community signifies in day-to-day practice with nurses. An examination of practice reveals that some resistance from patients is apparent. This resistance from patients, in the form of questions, is treated by nurses as a nuisance and an irritation. By exploring

these occasions this discussion illuminates 'how' such resistance is handled by nurses.

This chapter challenges extant views of organizational practices as those which attach people (entities) together (Ouchi and Maguire, 1975; Ouchi, 1981; Ouchi, 1979; Ouchi, 1977; Ouchi, 1980; Durkheim, 1972; Cohen, 1985). Instead, following Munro (1994), what is shown is that organization is as much a device for holding people (entities) apart. As has already been shown, nurses employ community as a device for 'detaching' themselves from patients. However, while nurses detach themselves from patients employing community this has the effect of attaching patients to one another in another work space. This feeds back to my discussion in Chapter 3 where patient performances with one another are different than those which nurses train them for.

The first example I present reveals how community, as a technology of control, has consequences for patients who fail to conform with standardized practice. Here patients are less receptive to 'go' with the flow and offer their preference for a particular community activity. When such resistance or questioning from patients arises, other issues in play, constituting this interaction, emerge for explanation. In this case, despite shared expressions, a virtual absence of shared meaning regarding an image of community between nurses and patients arises. This lack of shared meaning (between patients and nurses) produces misunderstandings, confusion and contradictions in situations where community is questioned by patients. In this chapter I also present an example which reveals how nurses and patients divide particular aspects of community work.

Patients' test an image of community in practice

Weekly activities on the ward are scheduled by nurses and patients during a Monday planning session. As already discussed, this planning session is identified by nurses and patients as "community meeting". The activities scheduled at each "community meeting" subsequently regulate daily activities for each week day. It is also noteworthy that due to fluctuations in the patient population, 'members of community', those present at the planning session may be different than those members present on any given activity day.

In the first instance each of the patients who took part in the planning session (Monday) were discharged from Bestcare and those patients present at the Friday activity, were admitted to the ward subsequent to the Monday planning session. Hence, those patients attending community activity on Friday had no input into what the activity was going to be. It is also important to emphasize that patients recommending such a change have (as evidenced by their attendance at community meetings) already been transformed into 'members of community '. This point is raised in light of the importance of attaining membership status (patients-as-members) to community in this ward. Furthermore, patients who initiate the issue of changing the activity have been exposed to expressions from nurses that community is "for patients". As discussed in Chapter 3, nurse Leona's advertises that "community meeting" is the patients meeting and her statements include: "on Wednesdays is an outing and it's your choice"; it "give(s) you an idea of how you're doing in community "; it "gives you a good idea to see how you're functioning"; and "you choose what you're going to bake" (refer back to pp. 54-55 or p. 67).

Friday, the day the art gallery visit was scheduled to occur, the current group of patients-as-members suggest a change in the activity because of hot weather. The patients suggest that due to hot weather an outdoor activity would be more enjoyable than touring an art gallery. At the time of this activity nurse Martha is unwavering in her stance and she informs patients that a change in the planned activity would not be permitted. Subsequently, patients and nurses visited the art gallery. It is relevant to note that no advance booking with the art gallery is required which might be expected to have effects on whether a cancellation occurred.

'Not to be changed': is noted by nurses

While patients and nurses were at the art gallery, a conversation between two nurses related to patients' expressed preference occurred on the ward. Nurse Leslie makes a passing remark to nurse Jennifer at the nursing station:

> Leslie: Martha said that the decision had been made and they were to stick to it. Several patients were upset that they had to do what Martha had said. . . . Rules are made for a reason and they are not to

be changed. The patients went to the art gallery and not the Botanic Gardens. [next turn of conversation focuses on a different topic]

Here Leslie relays a rigidity in Martha's interaction with patients. Leslie echos Martha's stance in this account to nurse Jennifer with: "rules are made for a reason and they are not to be changed". This interaction reveals that, according to nurses, planning and following through with those plans are important. Such decisions secure activities for community and in this way help to stabilize day-to-day practice.

Leslie and Jennifer move onto another topic immediately suggesting that this was not an unusual stance for nurses to take. This excerpt suggests that Leslie recognizes this issue may have some effect on patients. In this way, Leslie's comment alerts Jennifer that this may be a potential issue which patients might address upon their return to the ward. However, the short period of time devoted to this issue and the account from Leslie without disagreement from Jennifer suggests that this is not an issue that requires revising. From the nurses' perspective, they are aware that this question arose but that it was handled by nurse Martha.

'Not to be changed': is noted in kardex

The second time this issue is revisited by nurses occurs during kardex. In this case nurses note the patients' request to Martha that a change occur in the planned activity. The response of nurses in kardex was similar to Leslie's comments with Jennifer noted above. During kardex Leona states: "the patients asked for change the activity... Martha said no .. they are not to change planned activities". Jody says "the patients were upset about Martha's decision". As Jody spoke two nurses looked up and said "oh" and the work of kardex continued. I suggest that for-all-practical-purposes nurses view this incident as settled. However, I also suggest that this exchange acts to alert nurses that potential discussion from patients may arise. Nurses do not devote any more time to this particular issue in their discussions.

That nurses handled this 'news' in the way that they appear to, suggests that in their view, patients were faced with and had to come to terms with 'rules' of community. Effectively, their explanation is that rules must be followed. The decision has been made by Martha, circulated as taken as the

decision and now nurses stick together on this issue. The above brief conversation by nurses relays that this issue is treated as though it was for information only. In this way it is an organizational memo distributed here for nurses information. The effect is that of a warning signal.

'Not to be changed': is addressed by patients

The third occasion when 'not to be changed' arises, occurs when patients address this issue at the following Monday's community meeting with nurses. According to patient accounts with me, they had selected patient Ginger to identify the issue and she directs the patient inquiry to nurse Martha. The speech turns in the following excerpt are from patient Patsy, patient Ginger and nurse Martha. Nine patients and two nurses are in attendance at this particular "community meeting". Nurse Martha accounts for the decision she took in the previous week to 'stick' with the previously organized activity stating:

> Martha: Well actually we were told when this all started that the activity was decided on Monday so ah, unless the weather changes in which case we try to have an alternate anyway and we can certainly check with them. But no the, what is decided Monday stays because that was constantly happening, every, we would make plans for the week and every single day it was changed. That became a routine, so that's why, that's why, it's not that we are inflexible but it is just that that way we know in advance what we are doing and we make plans accordingly, get the Van ready and all of that sort of thing. So it is not that we are trying to be difficult, only trying to have a schedule that we can count on. So hopefully you can understand that. Every week people change within the hospital, sometimes the entire group changes in a week but we still stay with the same activities. So maybe you can help if someone new comes in to explain that to them, that it might not always meet what they would like to do but, to be patient and that that was what was decided. Maybe they can decide the next week. Did you enjoy it alright?
>
> (few seconds silence)
>
> Patsy: Well ... we kind of went along with it.
>
> Martha: Yeah, well, I think sometimes that's life isn't it, that we don't always get to do what we would like to.
>
> Ginger: Well we just thought we would discuss it
>
> Martha: Yeah, it is a good point. Is that understandable?

Ginger: Oh, yes.

Martha: Because the nurse [Amy] did come and say, "Are we suppose to change the program" and I said "No". That that was the agreement, that we were told to stay with what ever had been decided on Mondays. . . . . And yeah, that's why it is important to say what you want to do on Monday, so that if you are here on Friday then you know why that has been decided and then you can let other patients know.

Patsy: Once you get your people accustomed [missed two or three words on tape]

Martha: That's good. Okay, sure. It certainly means that if it is 40 above and we have planned a walk it might not be the sensible thing to do or if it is pouring with rain and we had planned to go say for a walk then we could change it but other than that we try to stick with it. So do think about what you really want to do this week. Sometimes it is even hard to do that, to know what you may feel like doing on Friday on Monday. I know it is difficult. . . . . Any other concerns that you may have?

Patients Patsy and Ginger have had conversational turns here, but the bulk of the time is taken up by nurse Martha providing her account. Patsy expresses her view that as patients "we kind of went along with it" which epitomizes patient positions in the ward. Patsy supports patient Ginger's expressed view, but Martha indicates that Ginger 'got it wrong'. What emerges is that Ginger, Patsy and other patients not in this particular strip of interaction took nurses literally in statements such as: "it's your meeting"; ... "do these things for you" ...; and "what you want". This test case results in Martha effectively minimizing patients' concerns and any discrepancy that they have noted with statements such as "we don't always get to do what we would like to" while placing the responsibility back on patients:

Martha: So maybe you can help if someone new comes in to explain that to them, that it might not always meet what they would like to do but to be patient and that that was what was decided. Maybe they can decide the next week.

Martha makes explicit that to be a patient in this ward translates in practice as "be patient". Martha places responsibility on patients and suggests that it is 'patient work' to "help if someone new comes in to explain that to them". Nurses exercise control over patients and "unless the weather changes" a change in activities is not considered by nurses. The account is used to exemplify one example beyond the control of nurses (the weather) that could

perhaps be used to convince nurses to make a change. Ironically, however, this is precisely one of the points raised by patients on the previous Friday upon which they recommended a change. In particular, as a result of it being 'a nice day' and indoor activity seemed unsuitable.

In the context of "community meeting", Martha privileges the issue of 'stability' of day-to-day practice and implies that stability is 'therapeutic'. From the nurses' perspective such stability makes it easier for the nurses as they do not have to be spontaneous, which is clearly part of the enacted strategy here. Only nurses decide: change is not permitted by nurses. It is important to note that I am not claiming stability is therapeutic. Rather, Martha is implying stability is therapeutic and she can make that claim as an expert. The point here is not a concern over any 'healing' powers of stability, simply that from the nurses' view stability is employed as a therapeutic issue. Also associated with nurses' work, juxtaposing stability and 'therapy' implies that if in this case, 'any potential therapeutic value' is unknown to patients that this stands as an opportunity for nurses to demonstrate their competence at 'doing nurse'. This is what nurses are for. Nurses are assumed to be knowledgeable about therapy. Martha constitutes herself as an expert in face-to-face contact with patients, legitimates her previous decision, reinforces it and treats the issue as settled.

Performing competently is important. This interaction underlines competence as a nurse, that is, competence is dependent upon being able to produce and sustain day-to-day practice. For instance: providing instructions; not being caught out without an answer or response to patients; always having the upper hand; and being seen to be directive. In these ways nurses are in a position to be viewed as the expert in relation to members-of-community (according to themselves and patients). Nurses competently maintain a relationship of social distance constituted through an 'expert stance' in relation to patients. In practice nurses appear to act out an obligation to remain in control even during face-to-face community interaction. For the moment further discussion over nurse competencies is set aside.

The above critical incident reveals that patients misunderstood what nurses intend by community and are confused when they realize that nurses 'meaning' and patients 'meaning' vary in practice. This underscores an absence

of a shared meaning in relation to planning activities and the binding quality that nurses associate as an organizational practice. That shared expressions do not entail a sharing of meaning is precisely what Cohen (1985) emphasizes in his work concerning shared expressions of community practices. He delineates that what members of a community share are 'expressions' not 'meanings'. In this way, Cohen problematizes the assumption that expressions *carry*' shared meanings'. This is vital.

As previously noted, Cohen points out that learning words do not "tell you what to communicate" but rather "gives you the capacity to communicate with other people" (1985, p. 16). This elucidates an 'ambiguity' over any meanings to be read into the term community. Hence his explicit distinction between 'shared expressions' and 'shared meanings'. There is no one-to-one correspondence between message sent and message received. Language does not 'express meaning' but it gives individuals the capacity to 'make meaning' (Cohen, 1985; Strathern, 1990). Munro (1992) extends considerations of meanings when he suggests that it is not simply a question of 'making meaning' but also that of disposing of meanings when understandings change:

> Meanings do not exist, as traditionally theorised, in a world which is parallel to the one of action. Against the abstractions of analytic philosophy, where meanings have tended to be treated as merely representational, disposal marks the facticity of the life-world. To avoid a dualism of words and things, it is important to recognise that meanings must always be embodied, whether in flesh or text or artefact. Disposal therefore is not just a matter of preventing diminishing marginal utility, of relieving the body from satiation, or of rescuing consciousness from 'information overload'. Rather disposal raises questions of *moving* among meanings, without invoking voluntarism or having recourse to determinism (Munro, 1992, p. 4).

I suggest that Munro resonates with Cohen in marking a shift in understandings and meanings as "communal" (Gadamer, 1989, p. 379) interaction occurs. Such a view extends Gadamer's view that 'understandings' are not pre-given but take their expression in the inter-subjective moments of talk as individuals ascribe meaning to language. Importantly, 'expressions' (language-in-use) are such that they provide space for expressions of individuality and allow for different meanings. In relation to the above discussed account of a community meeting the implications of assuming that

'shared expressions' equate with 'shared meanings' are that confusion and contradictions in day-to-day practice can result.

In keeping with the above account, the problem which patients identify (not being permitted to change the scheduled activity) is effectively 'thrown back' on them when Martha states: "so do think about what you really want to do this week". Martha maintains control and the problem of 'change' as treated here, implies that it has essentially nothing to do with her. What emerges is that the former group of patients had agreed to a visit to an art gallery and this choice is therefore binding for those patients presently hospitalized on this ward. Here, former consensus among patients (related to an activity) is used to ground a sense of stability in day-to-day practice for nurses.

In contrast to Martha's expressed comments, I suggest this incident reveals the "inflexibility" and "difficult" situations that 'organization' embraces. What emerges is that there is a dark side to organization. This is precisely Morgan's (1986) view when he claims that, for everything that organization 'organizes in', other things are 'organized out'. Here, despite the fact that the weather was in excess of thirty degrees Celsius, a walk in the Botanic Gardens is not permissible because this contingency is not part of what is taken into account when the art gallery activity was planned. Nurses draw on stabilizing properties of community during their interaction with patients to keep things running smoothly and deviations even those patients-as-members suggest are not permitted. Martha stresses the importance of stability in "every week people change within the hospital". She makes explicit that nurses make efforts to stabilize the day-to-day activities within the ward. Nurses' actions of 'sticking' with planned activities enable a functioning network of patients. This case exemplifies an 'extreme case' where all patients were newly admitted and nurses are able to sustain order by drawing from organized activities. Here, nurses constitute their competence as expert by being able to produce and sustain day-to-day practice, even those riddled with precarious circumstances.

As already noted, according to patient accounts and nurse accounts with me, on the particular Friday in question, patients' suggested that the previous 'scheduled community activity' (as noted by a former group of patients), be changed to reflect the preferences of the current group of patients. I now

provide a patient account which reflects patient confusion related to the way that Martha handled and discussed this incident. The same day that Martha speaks with patients in the above noted "community meeting", one interview account indicates a process of group consensus:

> Ginger: I kind of figured that would be the answer, but as a circumstance on Friday I thought that they could have taken into consideration that there were elderly people in the group the first Monday and there was not any by Friday. There were no elderly people. There were new people and we did have a plan. It is not like we just said we did not want to go to the art gallery. One gentleman had already been there. A couple of us preferred not to go there and we all were in a consensus to go to a park, so I can't see ... we even had a park name [Botanic Gardens]. We had done all our homework. I thought that could have been taken into consideration. It was not just that we did not want to go to the art gallery. We had a couple of reasons why we did not want to go and we also had a second a choice where we preferred to go and I do feel that maybe that could have been taken into consideration on Friday.

Ginger suggests that the patients had discussed and worked out a plan and an alternative presuming that, they did indeed have a say. She conveys that she does not feel that patients were considered in this situation. Ginger also suggests that, as patients, they did not 'trust' to spontaneity but had their moves planned in advance of the activity on Friday and had a consensus. She states: "we had done all our homework" and that "we had a couple of reasons why we did not want to go (...) we also had a second a choice where we preferred to go". However, that patients in practice were faced with Martha's firm decision suggests that they re-adjusted their collective position in face-to-face contact. I suggest that this indicates that patients know when to take a stand and can change directions, picking-up on interaction with nurses. Therefore, patients do not force the issue. Retrospectively Ginger states "I kind of figured that would be the answer".

This particular incident could be read by nurses as a 'potential revolt' by patients and a threat on their ability to maintain expert status. This test case illustrates that an image of community as something driven by patients, even when espoused by nurses, is clearly not a reality for these patients. Patients are compelled to cooperate with the stable features of community which nurses select to instantiate. Patients are to cooperate and fit into the organizational

device which nurses mobilize to legitimate day-to-day activities. Community is a resource employed to 'stabilize' day-to-day practice. Activities making up practice are not therefore to be turned towards maintaining patients' notions of community. Nurses use coercion where patients fail to see the benefits of community: sanctions are deployed (refer back to discussion on p. 121 or p. 147).

Valid community issues

As already discussed nurses purport that a "community meeting" stands as an opportunity for patients to 'work out' what is acceptable or permitted as a member of community. The next strip of interaction to be explored from a community meeting reveals one nurse's irritation when her taken-for-granted use of community is questioned by patients. My aim is to further elucidate a sense of similarities and differences in what community symbolizes for nurses and patients and how nurses mobilize community as a resource with patients.

In common with the last example, the next example arises from practice. This interaction occurs during community meeting attended by eight patients (speaking in the following excerpt are Ruth and Ginger) and two nurses (Martha and Leona speak in this excerpt). The following strip of interaction will first be presented to retain the momentum building at the time of this interaction between patients and nurses:

> Leona: . . .(looking through pages in community meeting book) . . its time to talk about any concerns you have, ah, you have on the ward...when you come into this ward you really don't know what's happening. Ah, we have an activity every morning ... and then every afternoon you have group therapy and that happens at one-thirty, and that's in the group room, a special room just off the entrance and that's also part of your treatment to go through,
>
> Ruth: I don't go to that.
>
> Leona: You don't go to that? Alright there's group therapists that
>
> Ruth: No?
>
> Leona: Okay
>
> Ruth: I go to the activity
>
> Leona: Alright you have another activity that you go to, ah there's group therapists the group therapists will let you know [Leona continues to speak about visiting hours on psychiatry

and then asks the following question] Is there any questions about that?

Ruth: I like, what about when I have my surgery?

Leona: Okay..well that will be between you and your doctor

Ruth: but that won't be easy because I don't . . . want the girls to not come up and see me

Leona: oh, okay, we don't have visiting in your rooms. We encourage the visits to be in the lounge areas but you know . . .

Ruth: Can they come and talk to me though?

Leona: Ruth we're always open to special cases so, we're not so rigid that...ah we'll cross that bridge when we come to it. Right now you're up and about so you're expected to visit out in the lounge. So we'll cross that bridge and address that problem when it comes. Okay?

Ruth: Yeah.

Leona: Uhm, any concerns about, that you have about being here, any concerns that you have like with the TV's or like the ah,

Ruth: ...the smoking room is terribly dirty all of the time

Leona: okay, that's a concern, ah, (turns page in book) we keep minutes and the minutes are kept right behind the calendar and the ah, and I will tell you some of the concerns from the he last couple of weeks ...we usually just write a list of the first name, the first name of people that ah, came. . . . . (Martha clears throat). Okay if they didn't like something that happened on the ward and they don't specify . . . ah sometimes there is concern about the telephone ah you know sometimes patients tend to take longer than the ten minutes that's ah, so they're not getting their turn on the telephone, okay?.... so if you know, if there are any concerns like that ah, you can bring them up at this meeting. I don't , I don't hear any concerns today. . . .

Ruth: Just Ret eating our food.

Leona: Well, that's a concern, that's a concern that has to be brought up, (Ruth laughs) that's something that we have to know about (sighs). Okay we will address that...has that been happening

Ruth: Quite a bit to me

Ginger: uh hum

Leona: Oh.

Ruth: I've told the nurses

Leona: We certainly have a fridge that we can put things in

Ruth: Have to put, just as long as your name is on it

Leona: Yeah, we can, we can address that also. You know if you have your food labelled in the fridge, you're certainly entitled to it.

Ginger: Does he not get enough on his tray . . . because he's always going like, even he is no sooner done eating and he's going through everybodys tray?

Leona: That's something that we are aware of, you know we won't discuss other patients but you know, ah, he does get adequate food and we make sure that happens but that is something that we will address. Until this morning that wasn't something that I was aware of as a concern but we will address that

Ginger: I think we just kind of noticed it's gotten worse in the last couple of days...for what it was

Leona: Well, that's something as nursing staff that we will address.

The enacted strategy for nurse Leona is to 'tell' or instruct patients about acceptable behaviours inside the ward territory. Leona does touch on a range of ward practices and their accompanying 'rules' (ie. visiting rules, telephone use, food labelling in fridge, and that patients are not to talk about patients who are currently absent). These legitimations give form to the type of practice inside this ward as though nurses are prepared, organized and aware of day-to-day concerns.

For instance, patient Ruth raises the topic of visiting hours. Nurse Leona states, "okay we don't have visiting in your rooms". This serves as the 'directive' or an instruction for those who are not familiar with such a rule. I suggest that Leona instantiates her expert position which is particularly obvious with patient Ruth and Ginger above. Leona's responses to Ruth are treated as if Ruth is interfering with her 'nurse' spiel to which she ignores or provides short responses to patient Ruth. In this session, not just Ruth, but, other patients receive 'instructions' from Leona's responses aimed at Ruth. The above

interaction also marks the economic of a group/collective of patients rather than dealing with one patient at a time.

During the course of this meeting several questions are raised by patients and directed at nurses. In each case, nurses successfully discount patient questions. Above Leona attempts to ignore or dismiss patient Ruth's comments. For instance Leona's approach to Ruth is condescending in spoken words and tone in: "Ruth we're always open to special cases so, we're not so rigid". Although spoken words state that "we" are not "rigid" Leona's action portrays that she is unyielding. Ruth continues to interject as Leona rehearses her speech surrounding community and what patients "get to do" from week to week. The use of words "get to do" plays against the rigidity she is currently demonstrating. The different topics arising from the above interaction are now addressed separately in terms of their relation to aspects of community.

On the issue of visiting hours, Leona takes the opportunity to remark that visiting is permitted between patients and friends or family members in the common areas of the ward. However, Ruth attempts to apply this 'rule' to her own situation and puts her inquiry in the form of a question. Leona reiterates an expectation of nurses that patients are not to visit with friends and family inside the boundary of patient rooms. When Ruth reminds Leona of a surgical procedure which she is scheduled for, Ruth is informed that this would possibly constitute a "special case" where visiting may be allowed in Ruth's assigned room. Leona successfully displaces Ruth on the visiting issue by suggesting that this meeting, would not be the time to make such a decision, for some future event such as Ruth's surgery. It is pertinent to note that, two days earlier, Ruth's surgery is reported in kardex for nurses (which Leona attended) and is scheduled to occur in three days time. In this particular case, planning in advance by Ruth, is treated as not appropriate. Given the emphasis on the 'collective' it may be that one patient's/person's issue, such as Ruth's surgery, is thereby not viewed as appropriate for community meeting. Leona attempts to keep the discussion moving and on another occasion she asks whether there are "any concerns about, that you have about being here, any concerns that you have like with the TV's or like the ah". She appears to try to include other patients in the discussion. In this sense, Leona opens the floor for questions

which suggests that she is interested to hear from other patients. In this speech turn, Leona encloses an example of an acceptable concern, something related to the "TV's".

One reading of marking out an example for patients is that Leona is subtly indicating that communal living arrangements among patients may be the focus of appropriate concerns. At this point patient Ruth draws attention to the "smoking room" which is "terribly dirty all of the time". Leona acknowledges that this is a "concern", but, provides no direction as to what action might be taken. Instead she turns through pages in the "community meeting book" which act as a registry of patients' concerns from previous weeks. That Leona ignores the "dirty" room, I suggest, may be read as a distinction between patient and nurses work. In this case, a "dirty" room in the communal area of the ward is considered a patient problem and not a nurse related problem. Whatever their rationale, nurses Leona and Martha ignore this as a concern as evidenced by their failure to address it in this particular meeting. What emerges is that the problems or concerns which Leona and Martha will address are selective and this one, they displace as a patient problem. Later this morning, I saw Ruth cleaning ashtrays in the designated smoking room which suggests that this may have been her interpretation of Leona's comments during community meeting.

Another attempt to come up with an acceptable "concern" for community members is registered by patient Ruth concerning "Ret [another patient] eating our food". In this case, Leona claims this as an acceptable concern. However, it is one that nurses already know about, so, it is not a concern for this session: Leona states that "until this morning that wasn't something that I was aware of as a concern". Earlier, during morning report (change over report) other nurses brought the issue of Ret's eating habits to Leona's attention. During "community meeting" Leona re-directs patients' attention to a food related topic by stating "we certainly have a fridge that we can put things in." She goes on to reiterate the rule and wraps up an instruction for patients in: "you know if you have your food labelled in the fridge, you're certainly entitled to it".

Another patient Ginger joins in the conversation levelling a concern for Ret asking whether Ret is getting enough food. Leona takes this opportunity to rehearse a rule: "we won't discuss other patients (when they are not present in the community activity)"; and states that he is getting "adequate food". This suggests that nurses have taken proper action to ensure that Ret receives "adequate food" while in hospital. Whatever is the case here, in the process of performing her competence as a nurse, Leona discounts patients' concerns for Ret. Patients are not to focus on concerns which nurses' view as belonging to their domain of work. The closing of this particular issue like this, leaves a clear reading for patients: patients are not to be concerned for one another.

Accomplishments and effects

The above discussion of "community meeting" suggests that there is a lack of fit between what nurse Leona treats as relevant and those questions which patients address. Leona displays competence by re-directing the conversation produced which acts to sustain order and organization. This enacts her expertise as nurse, as she is no doubt providing, in her view, stability for community in practice. These particular nurses handle contact with patients by maintaining control and they do not waver on decisions. Nurses use such interaction with patients to instruct patients how to 'do patient' in this ward. Patients are displaced and comply. Such discrepancies suggest that a sense of community which patients understand is problematic during their contacts with nurses. However, I suggest that it also precisely the patients' understandings that enable them to make sense of their experience with nurses on the ward.

During the above community meeting nurses treat the issue of what community signifies to them as unproblematic. They prevail discursively on patients to do the same, although what appears is patients' experience of confusion and contradiction. What these precise clashes reveal are properties of ambiguity related to key language (community). In this case, a patient's former view of community does not stand and is altered by what patients are currently being exposed to. Further each nurse and each patient has a slightly different view of community and therefore emphasizes different aspects in practice. This

produces variety, rather than stability: there is enough variation to make it difficult to pin down just what community does mean during nurse interaction with patients.

The features of community addressed by patient verbalizations (evinced by their questions) suggest that shared expressions and shared meanings between nurses and patients are limited in day-to-day practice inside this ward. Leona's expressed verbal interest in patients (invitation to address their problems or concerns) reveals an illusion in that, several patients attempt but fail to grasp what Leona is suggesting by community. The final dismissal of patients occurs when Leona states "you can bring them [concerns] up at this meeting. I don't, I don't hear any concerns today". This successfully dismisses Ruth's latest comment as well as <u>all</u> those identified previously in this "community meeting".

Several conversational expressions inferring regard are performed as part of Leona's 'spiel', however, she is not wanting to address problems expressed despite her spoken words which state the opposite. It is as though the more patients are provided with the opportunity to respond to this question (ie. 'any concerns?'), the more open to comments Leona perceives she is being with attending patients. However, with each concern that was initiated by patients, Leona displaces, silences, marginalizes or ignores them. Leona's performance can hardly be said to convey an interest in patient "concerns".

The calculative accomplishment of this meeting is reflected in further questions from patients following along in the same community meeting. These included: "When will Dr. Kramer [gynecologist] be in" which was responded by "I have no idea Ruth, but that is something you will have to check with your doctor [general practitioner] when he comes in". The next question to Leona from a patient was: "(s)hould I stay here" or go to the activity? Leona replies "(n)o you go ahead and go, but you discuss that with your doctor and with your nurse". Leona's comment suggests that she will not advise this patient which again conveys that a patient's concern as an 'individual' (a specific person) is not included in topics relevant to community meeting. I suggest a dialectic in practice is within view here. In particular, what emerges is

that forums ostensibly in place for patients-as-members are different than interaction where patients are treated as individuals (patients-as-individual).

During the next speech turn Leona effectively stops patient Ruth from talking with "(n)o, the time here is for, for uhm ward problems". This confirms that Leona will permit a discussion of topics which have to do with the collective of patients not individual patient's. During Leona's invitation to patients to 'address their concerns', Ruth's persistence was matched with Leona's. Another question comes from patient Ruth in: "I wonder who my nurse is today?" to which Leona states: "you'll have to go look." Next Leona extends her current conversational turn and changes the topic of discussion. Leona conveys not being interested in assisting Ruth to gain familiarity about what constitutes "ward problems" nor 'valid community issues'. Several inquiries from patients were over-ruled by Leona as not existing or are not "appropriate" for this meeting.

The above performance of community together with espoused policy in the form of patient handouts, such as a patient information brochure, provide contrasts with the enacted strategy above in that, patient concerns are displaced in order to maintain a smooth flow of day-to-day practice. Although patients are informed that "community meeting" is a time for patients to raise issues of concern for them while in this territory, such invitations turn out to pertain to very specific and acceptable concerns, none of which patients were able to identify during this session. However, mixed messages employed reassure patients that nurses are ostensibly interested in the communal welfare of patients inside this territory. Importantly, patient concerns and nurses' practices of displacement presented above are apparent in other community meetings and interaction between patients and nurses. Nurses detach themselves from patients. Community acts not only as a resource for nurses, it is brought into being in ways that help to produce and reproduce modes of participation that assist with nurses accomplishing their day-to-day work. Nurses deploy community as a device to detach themselves from patients and so replicate their hierarchical orientation in ways which complement wider organizational practices.

The above examination of community in practice exemplifies a range of difficulties, contradictions and mixed messages which arise for patients in their experience of community as practiced in this ward. This is revealed in the disparity between what constitutes valid community issues for nurses and for patients. Leona competently controls the direction that this interaction takes and in so doing sustains a sense of order and organization. Such competency props up community as prioritized and an image which nurses employ in day-to-day practices with patients. Leona's practices of displacement (silencing, marginalizing, dominating and displacement) enable her to read patients' behaviours as cooperative. She facilitates patients' 'stepping back into line' as enrolled members of community through the use of discipline.

It is important to note that nurses do not always discount patient views. I now turn to explore a suggestion from patients which had been incorporated into daily practice on this ward (several months prior to this ethnography). This former suggestion involved the division of work between nurses and patients in the ward.

'Know who your nurse is': division of labour

Shortly after the part of community meeting reported above, Leona devotes yet another conversational turn to state that patients' concerns are important. In the following excerpt Leona underlines this by inviting patients to express their concerns not only at this particular meeting "here", but that patients are "free to bring them up with your nurse at any time" during the week. In this way, Leona implies that patient membership has its advantages. Ostensibly, patients are not limited to raising problems at any particular time as they will have 'plenty of time' during their stay in Bestcare:

> Leona: Okay. If you don't have any other concerns we will go through and we will plan our week. And if you do have concerns during the week you do have this time here to bring them up and you're free to bring them up with your nurse at any time. (..looking around the room as she speaks..) You know about the nurses board so you know where your assigned nurse is listed so, you always know who your nurse is. You're aware of that, okay. So you should always know who your nurse is every shift. Okay. Now that was one thing that was brought up at community meeting, patients wanted to know who their nurse was.. so so, things do happen.

Here Leona identifies a previous change in day-to-day practice which arose from former inquiries at a "community meeting". In this sense, it would appear as though this stands as an example of an acceptable question from previous patients which was considered by nurses and incorporated into day-to-day organizational practices. Apparently the problem pertained to, documentation and distribution of that information: nurses assigned to patients during duty shifts. Leona explains that the former practice was questioned by patients who "wanted to know who their nurse was". By implication, this infers that patients did not know who their assigned nurses were. However, I suggest this particular example is noteworthy for another reason. During the collection of empirical material nurses claim that "primary nursing" (ie. name a nurse for each patient) was in place: "a routine practice for the management of patient care". Above Leona provides a post-hoc account and one which she gives as legitimating the current practice to facilitate patients awareness of who their assigned nurse is on any given duty shift. She states "so you always know who your nurse is" which is identified on the "nurses [assignment] board".

By way of contrast to the previous discussion at community meeting Leona reiterates that this community meeting acts as testimony to all those present that 'what patients are concerned about' is important to nurses and that "things do happen" as a result of patient comments to nurses. Although I suggest the previous displays are not those which support Leona's claim (ie. she rhetorically invites patient "concerns" four times but she consistently provides a rule for displacing patients in this face-to-face interaction) she has recalled an instance of something she can use to 'move' (Lyotard, 1984) these patients around further. Such conversation rests on patient enrolment in community (ie. commitment that it is good).

Leona claims that the 'nurses board' is for patients' use. This, now a sanctioned organizational practice, has some implications for patients and nurses. If patients are responsible for knowing who their nurse is, this is work for the patients and not work for the nurses. Such practices suggest that by dividing work amongst patients and nurses the overall work load is shared. Working together and dividing up 'the work' may be a reasonable expectation for practicing notions of community. I suggest however, that such practice

assists nurses' work. There is a two-fold benefit for nurses to incorporate this in their day-to-day organizational practice. The implications for patient work also figure into nurses time and what they use readings of patient performances for. By extension such an organizational practice may be a time saver for nurses.

As already suggested patient performances are read by nurses as performances of a patient's willingness to enter into therapeutic efforts/'healing' practices; here the work of becoming knowledgeable about the assigned nurse is important work for patients. The work of knowing who 'your' nurse is, has to be done by patients, in order for nurses to make a reading that patients are cooperative and assumed to be healing. Nurses take a patient's knowledgeability of 'their nurse identified on the assignment board' as some sort of a 'genuine' reading of a patients 'healing and insight'/commitment to community. This work has to been performed by patients, otherwise nurses have no way of reading how patients are assumed to be healing. In this case, I suggest that nurses take-for-granted that what they are reading is patient 'healing'. It appears as though 'healing' is a term employed by experts whereas I do not take-for-granted that activities with presumed 'therapeutic' value lead to 'healing'. The distinction between healing and therapeutic reveal matters of interest such as those addressed by Callon, Law and Latour in Chapter 1 (also discussed on p. 118, p. 144, pp. 231-232 and p. 245). The importance of ostensive healing above, also involves a division of work practices between nurses and patients. The consequence of saving nurses time is clearly part of the enacted strategy to have patients accomplish much of the work inside the ward.

Leona makes use of this occasion of interaction with patients to reinforce the now sanctioned rules that this is patient work. She appears to soften this rule by also reassuring patients that nurses are accessible to patients every day and at "any time". She goes on at some length to instruct patients how to determine who their nurse is. This is a significant message for Leona to pass on to patients as it reflects the distribution of work practices. She suggests that it is the patients' work to determine who their assigned nurse is and they must look on the board to determine this. This example suggests that it is nurses' work to record the appropriate name adjacent to the patients' name on the board. In turn, this example effectively distinguishes two work spaces, that is the work

space of nurses and the work space of patients. A distinction of work spaces correlates with other day-to-day practices between nurses and patients which I have shown.

In common with previous discussions where nurses constitute a demarcation or boundary between themselves and patients, this example also emphasizes such a practice. For instance, distinctions are created when Leona uses "we" in: "we don't have"; and "we encourage". This contrasts with patient Ginger's last turn in the previous strip of interaction where she states: "we just kind of noticed" where I would read the "we" to pertain to patients. This distinction is clearly reinforced in Leona's final turn of this strip of interaction in, "that's something as nursing staff that we will address" (emphasis added).

Finally, this example reflects an inversion of conventional care practices in this ward. Typically nurses inform patients that 'I am your nurse'. On this ward, patients participate in their day-to-day care by finding out who their nurse is. Such a reading also emphasizes how community is brought into being in ways that help to produce and reproduce modes of participation in day-to-day work.

Perhaps one of the most striking findings in day-to-day practices on the ward relates back to my discussion of patient performances in Chapter 3. During that chapter I suggested that patient performances are distinctly different than those nurses instruct patients to perform. Compounding this finding is that patients are by and large geographically and socially detached from doctors and administrators at Bestcare. I suggest that it is safe to say that nurses deploy community as a device to detach themselves from patients and so replicate their hierarchical orientation in ways which complement wider organizational practices at Bestcare.

I now turn to discuss how patients get along in day-to-day practice when they are detached from nurses.

Patients attach themselves to one another

The above examination reveals that there are several issues which arise for patients that appear to contrast with nurses' conduct of community and patients' view of community. One further example is presented to reveal that

community for patients in practice is 'different' than that for nurses in this ward. In contrast to aspects of community that were illustrated by patients in Chapter 3, I show how some nurses express an element of surprise in the ways patients enact community. As previously noted, what emerges is that although community is an important resource for nurses, that nurses are discursively unpreoccupied with patients 'doing community' in the ward beyond the times which are established for activities.

The following section investigates transcripts from "group". On the previous day of group patient Oliver stood up and left group while it was in session. During pre-group (the day of the following excerpt) nurses Nora and Leona (filling in for Tina during her holiday) decided that "the group will need to deal with him. He needs to be confronted for his behaviour". This provides another example of how the content of group is planned by nurses or that nurses decide in advance, what the content of group will be without members' input. The approach to "confront" patients in this way is referred to in discourse pertaining to 'group therapy' to assist patients to be accountable for their behaviour and the effects of such behaviour on others in group sessions (cf. Bloor and Fonkert, 1982; Wright and Leahey, 1984). In this sense, Nora and Leona's plans were consistent with contemporary views of how to conduct 'group therapy'.

Similar to nurses' discussion, here the importance of patient attendance is being suggested as relevant for not just nurses, but, also for group members (patients-as-members). In other words, patients are being placed in a position where they are to obtain an account from Oliver as a therapeutic work project for this group. During group Nora raises Oliver's 'unpermitted exit' as the content for group discussion:

> Nora: I notice how you seem to be feeling a lot better than yesterday (looking at Oliver). I'm wondering if the group wants to talk about yesterday or?
>
> Patsy: He was just having a bad day.
>
> Nora: So it's something that you don't want to bring up to him?
>
> Ginger: . . . We did with him (nods and looks at Oliver), we let him know that we missed him (ha, ha).

Nora: So that's something that has been resolved amongst yourselves?

Ginger: Uh-hum. Yeah.

Patsy: We carry on group out there too.

Ginger: Yeah, we do.

. . . . (laughter among patients) . . . .

Nora: I guess that's what happens with in-patient ward, you get relationships outside as well.

Ginger: Well, we all got to be friends, that's good, I am happy about that, I feel really good about that.

In Nora's first turn in the above strip of interaction she attempts to initiate the discussion to "confront" Oliver. As noted, Nora identified such 'confrontation' as a plan for this particular group in discussions with Leona at pre-group. Patient Patsy's first comment indicates that "he" is Oliver. Nora then asks "(s)o it's something that you don't want to bring up to him?" Patient Ginger takes a turn and indicates that these patients have already discussed the previous day's events. In contrast to nurses, Ginger translates his absence to the notion that patients "missed" him which conveys a different quality than that which 'confrontation' implies. Here, quality conveys the experience of, what Turner (1985) refers to as "communitas which is relatedness among individuals without judgmentality" (p. 124). The atmosphere of community among patients as a 'norm' is supported by Patsy when she says "we carry on group out there too." Ginger corroborates such a view with "yeah we do." At this point Nora indicates that "I guess that's what happens with in-patient ward, you get relationships outside [group] as well".

These patients indicate that for them, interaction with one another is not limited to face-to-face contacts when nurses are present. While Nora expresses her view that she can conceive of patients interacting beyond group (ie. in that patients are enclosed together in a particular geographical space in the ward), Nora's comment may arise from three alternate and perhaps related readings. First, there may be an element of surprise that patients have "resolved" the issue of Oliver's unexpected exit on the previous day.

Second, the group therapy strategy is to 'keep what happens in group' as confidential and as content for group (as a collective) to work through. This expectation is typically announced to patients when they sign the consent form for group. However, patients took it upon themselves to deal with Oliver independent from group (which excludes nurses). I suggest this caught both Nora and Leona off-guard. Nurses did not take this opportunity to reinforce the 'rule' but instead Nora, after some period of silence and looking back and forth among group members asks: "(s)o what do you want to do today?'. With a view of group therapy, patients 'doing community' beyond the walls of this established context for group undermines this group rule of conduct. Importantly, such an occurrence also draws attention to what patients do when they are distant from nurses.

The third potential reading relates to the second but in particular to nurses as the 'group leaders'. Nora and Leona have missed their chance to focus the group discussion on Oliver's previous day's behaviour. Nurses did not have anything else pre-arranged. The above excerpt stands as an instance of face-to-face interaction with patients which is not employed as an occasion for spontaneous interaction, rather, nurses' discussion with patients is *pre-figured* In one sense, this missed opportunity reflects upon their competencies. I suggest that it is also specifically nurses' work as opposed to patient work. As a result of nurses' failed plans to confront Oliver, this affects the remainder of the time that group continued. Efforts by Nora and Leona were employed to 'keep group going'. On one occasion Nora attempts to prompt group members with: "I leave it to you guys". Ultimately, group is concluded thirty-five minutes early, so, the typical running time of 60 minutes is reduced to a 25 minute group. What emerges is that if patients 'do community' beyond the bounded geographical space of group, there is a risk (for nurses) that what they plan in pre-group will, as in this case, not sustain planned discussion for group members. Here, nurses' plans have been usurped by patients. Drawing from Lyotard's (1984) discussions of 'novel moves', patients have displaced nurses with a novel move. The competency of these nurses may be further revealed in that one typical nurse leader (Tina) is absent and Leona is assigned to 'take her place'. That patients took it upon themselves to "resolve" 'apparent' issues

with Oliver sufficiently undermined the continuation of group and it became difficult for nurses to prolong interaction.

This excerpt from group reveals another aspect of nurses being 'detached' from community. The work that patients do outside of group makes it difficult for nurses to access, especially when nurses view of community centres on scheduling patients days. Two nurses informed me during interviews that they 'see it (community) happening' when patients "develop relationships", "exchange telephone numbers" and "you can see them talk and stuff". However nurses do not appear to connect patient interaction with one another to community that nurses make efforts to advertise and mobilize. Minimal comments from nurses relating to community, other than to its scheduling function, suggest that, for-all-practical-purposes nurses draw on community as a functional device. They are discursively unpreoccupied with the way patients' extend community beyond the narrow functional understanding enacted by nurses. It is beneficial for nurses if patients talk to other patients as it reduces the chance of nurses being disturbed and they can get on with other 'do nurse' work. Also, nurses do not stop patients' talking with one another as, a benefit of the distance which nurses produce acts to keep day-to-day practice running smoothly (nurses detachment from patients). In this sense, nurses 'set up the production for performances' and patients 'do community'. Nurses are not concerned with how patients make sense of their experience of community in the ward. Nurses work to establish a functioning network and they accomplish such a 'entity' with help/work from patients: a functioning network is held together. I suggest that what confuses patients is that they initially take-up community believing that it applies equally to nurse-patient interaction and patient-patient interaction.

I also suggest that the above discussed serious of attachments and detachments mark a second work space being created within the daily schedule where patients, as above, are left to do community. In this case patients are left for large periods of time without supervision. The above case also suggests that, rather than nurses specifically instructing patients on how to conduct themselves, nurses leave open specific ways in which community can be interpreted by patients. In the above case concerning Oliver, between the time

of one group session and the next scheduled group session, patients engage with each other in ways which appear to reflect everyday understandings of community.

Nurses use of community 'attaches' patients to one another and largely 'detaches' themselves from patients (patients-as-members). Nurses mobilize community as a technology of control in order to accomplish 'action in a block' during face-to-face contacts with patients. Nurses mobilize community as a structure and as a resource during face-to-face contact with patients to displace patients and distance nurses' from patients'. Nurses produce patient 'attachment' to one another and 'detachment' from themselves. Employed in these ways nurses constitute themselves as 'leaders' of community produced and reproduced by their managing patients at a distance. Through nurses' enactment of instructions and expectations, patients are dominated and controlled by nurses employing community as a device for detachment. Community is as much a device for detachment of persons as it is for attachment of persons.

Effects of community training

It is important to consider discourse effects of patient-nurse interaction during other interaction such as in patient-patient (and family members) interaction. What emerges is that patient's pick-up and reproduce aspects of what they hear nurses doing while patients interact with others. To elucidate this I provide the effects of nurses' talk on patient Oonaugh which appear during her last group session with nurses on this ward before discharge from Bestcare. Secondly, I provide an excerpt of interaction between three patients to investigate their talk when distant from nurses. Thirdly, I present an excerpt from an interaction between patient Ginger and her husband Baxter. Finally, a fourth example arising from an interview account with patient Ginger reflects how "choice" (discourse) is reproduced in patient talk with me.

During Oonaugh's final group session nurse Nora prompts her to 'talk about how it feels getting ready to leave hospital'. Oonaugh claims that she is "scared to leave" and Nora requests that she expand on this theme:

Oonaugh: I don't really know, I just I don't really know, a man or something, I don't know, what I am scared of I'm just scared. I guess you know . . . I just wonder if I can find someone?

Nora: . . . A boyfriend.

Oonaugh: (looks up to Nora) Yeah (nods).

As will be discussed further in Chapter 7, nurses consider that part of Oonaugh's 'problem' relates to her 'not having a boyfriend' and this issue arises during nurses' discussions with one another as well as being identified during group with patients. Nurses have settled on this view and 'move' Oonaugh around in attempt to get her to see this as an issue during her hospitalization in ways which reflect how nurses have *pre-figured* a patient (pp. 188-189). Above in her final group Oonaugh accepts their view and makes this public to members of group. This instance represents nurse-patient interaction and how nurses take opportunities to reiterate their perceptions with patients. In turn, nurses' work with patients effects patients' views of themselves.

Another strategy which nurses use during interaction with patients is the use of analogies. For example, nurses parallel 'healing' or 'getting better' with climbing a mountain. The following interaction between patients Ginger, Patsy and Oliver occurs while they are sitting in the common area of the ward:

Patsy: I was talking to one of the nurses this morning and she said "You probably will fall back, but at least maybe where you fell to here (motions with hand) last time, you will only fall to here (motions higher in the air), the next time, each time you build more, and that won't be so devastating". So that's a good positive thing to look at when you start feeling low.

Ginger: That's kind of like the mountain I was talking about last week. How you slip down. I know that will happen to me to but

Patsy: Put your security rope on.

Ginger: Yeah.

Oliver: Not too much though. Not to much security rope. You can do it, you can do it. Just going to have to get your confidence back and the next thing you know, you will be doing much better . . . go for it. Don't hang back to much.

Patsy makes explicit that she has picked-up from a nurse earlier today that "(y)ou probably will fall back" but a supportive tone and delivery of this

message is passed on to Ginger. In addition, patient interaction with one another in a second community work space identified earlier, resonates with discourse effects of nurse-patient interaction. Above patients pick-up on discourse employed by nurses and reproduce these particular ways of 'seeing by saying' during interaction with one another. This resonates with Munro's (1993a) discussion of Foucault'slinkage between discipline and discourse. In the context of this discussion, what also appears is that the disciplining effects of discourse, also make visible the materiality of the spoken word. Munro emphasizes that, "to say what can be seen" (p. 15) connects with the notion of expertise which underlines a sense of authority. He explains:

> The notion of discourse is perhaps the most difficult of all Foucault's (1970) terms to define and yet, with the notion of practice, is his most central term (see also Hoskin, forthcoming). A discourse is more than a set of terms in use, since it has *disciplining* effects. In that it is related to the notion of expertise, it is necessary to enter a discourse in order to have the authority to *say* what can be seen. In this sense, a discourse governs, as Munro (1993) points out, spaces of representation, more than it dictates representations of spaces (p. 15).

Patients employ discourse which enables them to "say what can be seen" which is exemplified by their claims that 'they get better' or 'heal' and their community performances. As Munro (1994) points out, Foucault's emphasis on visibility should not be mistaken to be suggesting only the visual sense is significant. The importance of the auditory senses should not be underestimated in the constitution of discipline and disciplining effects of language. As discussed the above examples reveal some changes and some disciplining effects of discourse by patients.

Another tactic that nurses use in their interaction with patients revolves around consideration for others and facilitating patients to not focus on themselves. For instance, in group nurses mark patients talk when patients speak of 'I' and when they consider the consequences of what they may be saying in relation to others in group (and presumably by extension to others outside of group). This particular tactic is employed, for example, by nurses when patients are displaying emotions (crying, anger and so on). The following example appears to reflect such a tactic as it is employed by patient Ginger and

her husband. In this way, I suggest that discourse effects are not only reflected with other patients but that patients reproduce these in interaction with others.

In an excerpt from an interaction between Ginger and her husband Baxter, she says to him that: "(y)ou have to be a lot more positive than you are. You are very negative now. Your speech is very negative and they are "I" features, I Baxter. I, I, I". In this case, Ginger is attempting to get across to Baxter that he should: 'be positive', 'alter his speech' and not centre on himself. These were not concerns expressed by Ginger of her husband during the early stages of her hospitalization. However, her speech, has since altered. The matter of her speech is also noted in the same conversation between Ginger and Baxter presented above. Baxter's comments to Ginger: "and you talk differently. I don't know what's happened to you". Baxter expresses a difference in Ginger's 'discourse' during her time in hospital.

The next example also reveals another effect of being in hospital for patient Ginger. At the time of this excerpt, she has been hospitalized for 8 days and has attended 2 community meetings:

> Ginger: It was to me, kind of this morning, too, being with my second time for community meeting. The first time I thought "Well, you kind of go along with the flow". But I kind of feel sorry for the new comers coming in, because I can, this morning with a newcomer in the group, they were acting like I acted last week for the first time. And you don't say anything and you don't give too much of your own opinion because you are just going with the flow. But by the time you are there, the second and third week I can see why maybe you would maybe want to voice some of your own concerns. You can help make some of your own choices of what you want to do for activity and to a point that is important. I think especially for people who don't know how to make choices. (...) This time they are allowed to make the choices which I think is good for them. Choices are important for all of us.

Ginger suggests that since her first "community meeting" she can "see" how important attending is and that the issue of 'choice' is one notion that she claims is important. She also makes explicit that "by the time you are there, the second and third week" that she can "see" that patients may "make some of your own choices". As noted in Chapter 3, "choice" is something which nurse Leona emphasizes with patients during community meeting (discussed on pp. 54-52). Choice has had an effect on Ginger and is reproduced here in an account from Ginger to me. This exemplifies both, the panopticon effect and the effect

of power which reveals how there is a movement between one community space and others: community work spaces are not water tight.

Here, a mixing of metaphors, following Pesmen (1991), enables a view of how different parts and relationships cannot be synthesized from one point of view: there are no absolutes for depicting a 'reality as truth'. Also, Strathern's discussion of partial connections reveals that movement along similar modes of ordering and associated terms (one point of view) sets up relations to a different point of view. The visualization that community work spaces are not water tight, reveals how there is a fluidity/movement from one community work space to others. Nurses and patients can transport (export and import) discourse from one work space to others. Just as when a stone is dropped in water the ripples remain visible long after the stone disappears. Patients re-materialize nurses' presence, drawing from discourse employed during nurse-patient interaction. Structures have effects which extend beyond their initial and intended instantiations. It then follows that community as a structure, although initially employed as an organizing structure by nurses, effects patient performances with others. In this respect, power is not just domination over another, people export power effects from one situation to another. There is a spill over from one community space (ie. nurse-patient; patient-patient; nurse-nurse and patient-significant others) to another. Here, nurses' effects on Ginger in one work space are present with me even when nurses are absent. I suggest images of water and work spaces are effective in conveying how contextualizing enables extensions to other theoretical domains. The very co-existence of discordant metaphors reflects the aim to be creative and move readers "back and forth between text and context" (Fernandez, 1986, p. 181).

In these ways, language of patients or the type of discourse they employ conveys their community training with nurses. As already noted, the discourse ("choice") renders control invisible, as well as, the act of 'choosing' represents a discursive practice. Importantly, the examples with patients Ginger, Patsy and Oliver as well as between Ginger and Baxter also reflect that, even when the nurses are physically absent, patients are able to constitute nurses' presence while patients engage with one another and their family members.

In relation to the approach taken in this study, accounts such as Ginger's above reveals what methods, she employs in day-to-day practice with me. What I can claim is limited by my ability to come to terms with and identify the methods which those persons in day-to-day practice use in representing themselves. Here, the methods which persons use to represent themselves as patients and members of a community to others enables a multiplicity of readings of practice. Also part of my methodology has been to enable readers to make some of the moves. Here, privileging the auditory medium is an effective way for readers to attach and detach from aspects of community in the day-to-day of one hospital ward.

This chapter supports previous analysis and discussion concerning the use of and implications of community in this ward. Specifically, 'community' enters, first as an image, second as a structure. As a resource, 'community' enables mobilization of patient action in particular ways at particular times. Nurses recursively accomplish patient performances of community as they draw on 'community' as a resource. In this way, there are partial distinctions, but they are not fixed, and partial connections, but these also are not fixed (Strathern, 1991; 1992). Hence, nurses play between ambiguity and stability in espousing community, provide multi-variant conditions for a patient's performance at any moment and time. What emerges is that nurses maintain control of a collective of patients while deploying community.

Chapter 7

Nurses private production: simulation

> To dissimulate is to feign not to have what one has. To simulate is to feign to have what one hasn't. One implies a presence, the other an absence. But the matter is more complicated, since to simulate is not simply to feign: "Someone who feigns an illness can simply go to bed and pretend he is ill. Someone who simulates an illness produces in himself some of the symptoms" (Littre). Thus, feigning or dissimulating leaves the reality principle intact: the difference is always clear, it is only masked; whereas simulation threatens the difference between "true" and "false", between "real" and "imaginary" (Baudrillard, 1988, p. 167 - 168).

Introduction

This chapter examines work practices of nurses as they are enacted with other nurses. As signalled in the previous chapter, patients and nurses accomplish distinguishable work spaces. This chapter explores the segregated work practices which comprise much of nurses' daily conduct with each other. Segregation accomplishes a 'geographical detachment' between nurses and patients as well as a 'social detachment'. Importantly, the work nurses do with one another is held in geographical spaces visibly separate from contacts with patients.

That nurses also work at some distance from patients suggests that these activities are intrinsically different from practice already discussed and require separate examination. Here, geographical distance also imposes an emotional distance from patients regarding such work. A salient feature of nurses' private work is that during interaction nurses are physically present with patients. In contrast, in nurses' work spaces the physical absence of patients is critical.

In these work spaces nurses talk about each patient as an individual (persons-become-individual). The work that nurses accomplish in these work spaces has consequences for the approaches nurses make to patients. This type

of nurse practice contrasts with that featured in an earlier chapter where the focus was on how only some patients enrol into 'community'. In this region, the work accomplished pertains to all patients on this ward. In relation to emerging figures of persons, here, person-as-patient-become-individual. In this work space, one aspect of 'do nurse' is to talk about patients: 'doing nurse' is to simulate patients. In contrast also to the marked exclusion of patients as 'individuals', I will show how a third work space in constituted in which aspects of community emerge. Here patients participate only in their absence:

> In this passage to a space whose curvature is no longer that of the real, nor of truth, the age of simulation thus begins with a liquidation of all referentials - worse: by their artificial resurrection in systems of signs, which are a more ductile material than meaning, in that they lend themselves to all systems of equivalence, all binary oppositions and all combinatory algebra. It is no longer a question of imitation, nor of reduplication, nor even of parody. It is rather a question of substituting signs of the real for the real itself (Baudrillard, 1988, p. 167).

The aim of this chapter is to go beyond past assumptions of nurses' daily practice and explicate mechanisms which they employ in day-to-day activities with one another. Nurses organize and regulate their day-to-day activities with one another to create routinized work. However, all action has consequences, effects and products that can be further drawn upon and a discussion of the implications for both patients and nurses is delineated. Nurses' routinized work provides stability by sustaining the smooth conduct of day-to-day affairs.

As already noted, nurses simulate patients during these private work spaces. These performances by nurses' enable them to be informed about all patients as well as constitute the basis of their accountability. Baudrillard's (1988) view of simulacra and simulations will be drawn on. In this view, he suggests that "to simulate is to feign to have what one hasn't" (p. 167). Through simulation nurses transform each patient into a particular identity. To help show this, Turner's (1967) use of rituals as transformational are drawn upon. Nurses' *kardex* is a ritual. This view corresponds also with Wolf's description of nurses 'change over report' (1988a; 1988b; 1989). The social accomplishment of patient identity is facilitated by nurses drawing on sources/artefacts (charts, standardized tools) which act to 're-affirm' the identity of a patient which nurses construct and pre-figure. Another recursive feature which nurses enact

is a 'collective mind approach' or a 'collective agreement' in their work spaces with one another. Here Saferstein's (1992) "collective cognition" will be drawn upon to help reveal effects of such nurse practice (p. 63). Saferstein claims that collaborative interaction enhances the production process through developing the input from a variety of expert areas. Following Fernandez (1986), I will show how nurse performances of patients reveal their 'mastery' of patients. As before, I am not claiming that there can be theory free ethnography. In this chapter I am using theory introduced by the above noted authors. As already noted, it is not possible to not pre-figure space, so I have attempted a methodology which safeguards against the problematics of pre-figuring spaces more than necessary for empirical study.

Reflecting back on previous discussions, I have shown that one way in which nurses get to know patients is through community activities. Although nurses claim that one-to-ones are routine, in practice this does not appear to be the case. This finding echos Altschul (1972) who claims that long periods of time pass when supervision is the only activity of nurses. Cormack (1976) indicates that only seven percent of a nurse's time is spent talking one-to-one with patients. Macleod-Clark (1982) suggests that one-to-ones rarely occur between nurses and patients. However, as will be shown, nurses do not rely on conventional face-to-face contacts with patients to become familiar with patients as they can accomplish such familiarity through a different mode of practice. In private, nurses construct individual patient identities through developing stories.

'Creating space': the private domain of nurses' work

Nurses routinely discuss accounts of patients. One particular forum where such accounts are relayed occurs during daily "kardex". During an interview one nurse informs me that kardex is an opportunity to "go through each patient" and account for "what's happening with all the patients":

> Leona: kardex for staff, we go through each patient and do problem solving together as staff. . . I find the most helpful thing is to bounce ideas off one another or like others might be observing things that I'm not. With 30-40 patients on the ward, you have to have an idea of what's happening with all the patients and kardex gives us an idea of what's happening with all the patients.

Leona suggests a collective approach is employed when she says that nurses "bounce ideas off one another or like others might be observing things that I'm not". She suggests that this type of approach to "all" patients is "helpful" for nurses. Another nurse, Zana, relates "kardex" to its placement in daily routines suggesting that kardex acts as an occasion to discuss "what it is we [nurses] have to do [and], haven't done":

> Zana: kardex uh, report sort of half way through the shift to find out how our patients are doing and sort of get it all coming together and figure out what it is we have to do, haven't done. Um, which way we're going to go. (...) so we know what's happening.

Zana identifies this collective practice of nurses and their management of the direction of care "so we know what's happening." In this way, nurses' talk is espoused to occur in a forum which is similar to Saferstein's view of meetings between a range of experts (ie. producer, writer, director, script assistant, sound editor, production assistant, associate producer, and so on) who exchange information and their respective frame of reference about "directorial concerns" of other participants (p. 81). He claims that one spotting session:

> was not merely an opportunity to receive orders from superordinates and decide how to administer them. Ideas and plans for subsequent action that differ from those previously developed result from such work (p. 81).

The collaborative work which occurs in such sessions are what Saferstein (1992) calls 'collective cognitions' or opportunities to enhance productions. These forums are "the basis of the working relationships among the participants" (p. 82). The above accounts from nurses imply similarities to those just provided from Saferstein's work. I suggest that nurse accounts reveal that they practice a routine activity which occurs geographically distanced from, and therefore contrasts with, work they do in face-to-face contact with patients. In such a forum, nurses review each of the patients with other nurses. Another reason that makes these particular activities important for study is that, the intervals of time which nurses spend with one another rests on patients being physically absent (see Table 1, p. 51 for daily schedules).

In such forums, accounts which nurses claim have been given by patients are reproduced within this nurse work space. In turn, these reproductions are employed by nurses in subsequent contacts with patients.

This is a typical view of nurses' use of other discussion periods such as change of shift report (Wolf, 1988b; Wolf, 1989). Such accounts are taken-for-granted to be based on nurses' observation of a patient's conduct with other patients, as well as, an account of interaction which may have taken place with nurses. As will be shown with patient Oonaugh, nurses construct a view and then work on the patient in the direction which reflects nurses' views and underlines how patients are pre-figured by nurses. I now provide a series of conversations among nurses on three separate occasions concerning one patient.

Emerging account of a patient

During post-group, nurse Tina initiates a discussion with nurse Nora about patient Oonaugh who attended her first group session on this particular day. The time of day is 1420 hours and this particular day is Oonaugh's third day on the ward. Tina and Nora are in the process of going through each member who attended group and charting as they speak. As it happens, Nora is Oonaugh's assigned nurse for the day.

Tina: Oonaugh. (Opens green binder / patient chart and begins to write.) Tearful, fear of criticism

Nora: How do you. . . spelling on that?

Tina: critic .. ism.
She's kind of a people pleaser.

Nora: A perfectionist sort of

Tina: Needs lots of reassuring.

Nora: Is she married or anything?

Tina: I don't know, I haven't had a chance to read her chart, I'll look. . . (flipping through pages in green book). No, she's the one that wants a boyfriend, she lives at home with both parents. (. . . pages turning . . .) She needs a social history done. Don't you think?

Nora: Um-hm.

Tina: There's got to be more to it than this.

Nora:
Where does she work?

Tina: Uh - ASDA Cafeteria wherever that is. . . . . Oh yeah, there is one here. . . . . Can't think of any major things that

Nora: She gets along with her family well

Tina: She's asking, absolutely, oh, "Describe your first boyfriend / girlfriend - none". [reading off pages in chart. A "social history" is found in Oonaugh's chart as the following questions are responses to some of the questions on the social history] "Describe your sexual experiences, none". "Have you ever been sexually / physically abused, none."

Nora: Maybe that's what she needs, sex.

Tina: Oh (Nora and Tina laugh). That's what Dr. Kramer said this morning .. "You know if one could prescribe a boyfriend and a bottle of whiskey." And he said "Well if she stays around here she's liable to find the two of them in one package".

Nora: Yeah.

Tina: ASDA Cafeteria.

Nora: Oh yeah.

Tina: Eight years.

Nora: How old is she? Sixty-four . . . she's twenty-five years old.

Tina: Sounds like, you know.

Nora: (laughs) I wonder why? So she lives with her parents and then when she graduated she worked at ASDA.

Tina: Yeah. Never had a boyfriend or anything. Family assessment would be quite interesting. . . . . .She's got an older sister.

Nora: Um-hm.

Tina: Find out some of this in here.

Nora: Anything else? (. . . pages turning . . . binder clips close)

This excerpt reveals that Nora and Tina are at 'ease' as they discuss anecdotes about Oonaugh. I suggest the above conversation reflects Saferstein's view that participants "talk about the material at hand and prospects for subsequent work on it" (p. 81). I also suggest that despite Oonaugh's attendance at group, neither Tina nor Nora appear familiar with her as a person. However, Tina's statement

that "she's the one that wants a boyfriend" is an anecdote circulating among nurses. Nurses interpret Oonaugh, not having a boyfriend as her 'wanting' one. Neither Nora or Tina have read Oonaugh's chart prior to this occasion. Later in this same post-group Nora and Tina return to Oonaugh as they decide what to talk about in group the following day:

> Nora: Maybe ... should bring something up about family ... I don't know about Oonaugh, but all the other people have pretty strong family issues. I'm not sure just what, but, something ...
>
> Tina: You know, do you have Oonaugh? (Nora nods) I wonder if she's able to take in something ...like I love that sheet on cognitive distortions [written exercise to help identify characteristic ways of distorting reality about oneself] [1] and she might learn something. . . . . .

Following along with patient Oonaugh, at kardex the next day, nurse Alison calls out Oonaugh's name as other nurses 'toss in' their anecdotes about her:

> Alison: Oonaugh Kelly. She had her CAT scan,
>
> Jody: uh hum
>
> Alison: and what else?
>
> Jody: She still has a mild headache, he [Dr. Kramer] hasn't requested any analgesic for it though. She is quietly spontaneous. She said that she is feeling a bit better today but still has periods when all she does is cry, starts to cry. Very uhm, medication orientated to treat the depression. . . . . What is the scoop with her and her parents?
>
> Alison: I don't know . . . why do you ask?
>
> Jody: I just wondered if maybe there
>
> Nora: She talks like they just get along fine and she had a happy childhood and that, no problems
>
> Jody: yeah, I just wondered if maybe there might be some outstanding issues with them that might be coming out.

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[1] One example of a cognitive distortion is: 'All or nothing thinking' where an individual see's themselves in black-and-white categories. When an individual's performance falls short of perfect they see themself as a failure. Other characterizations include the following: overgeneralization, should statements, labelling and mis-labelling, personalization, jumping to conclusions and magnification or minimization. For contemporary reviews of 'cognitive therapy' see Reynolds and Cormack (1990).

Nora: (laughs) Maybe that they think that she is too old to live there.

Jody: Well that was probably my first clue, of something, I don't know, it just seems funny that somebody at 25 would be that contented to stay with her parents.

Alison: Unless she has been really depressed for

Jody: She has been. . . a year and a half

Samantha: [I can't make out a short speech turn from audio-tape]

Jody: Yeah, and she worked part time at ASDA in the cafeteria for 8 years. She, I asked "If there was anything she would like to change," you know, ah, and she said "No".

Nora: She needs a change. . . Miss Perfect.

Jody: No, "I'm content with my job I like it, everything is just fine" [mocking tone], which is fine. I mean, she doesn't strike me as someone who would be content to stay at ASDA for 8 years in the cafeteria. . . . . I gave her some information on groups and some of their groups. She might not get anything out of them but...they can refer themselves now, can't they?

Nora: Yep.

Jody: I just wondered maybe if there were some issues that she couldn't express because, because of the depression covering, and

Alison: Not that we have heard so far. We have all just kind of been focusing on her affect and things and she's cheerful ah, and her headaches and stuff like that. [on to next patient in registry]

The above excerpts pertaining to patient Oonaugh are provided here to exemplify how a collective account takes shape in nurses' discussions with one another. These series of excerpts will be reflected back upon as the discussion of this chapter ensues. For now it is sufficient to note that nurses easily contribute to an account of Oonaugh amongst each other. The above excerpt conveys nurses current focus during their contacts with Oonaugh: "we have all just kind of been focusing on her affect and things and she's cheerful ah, and her headaches and stuff like that". However, what appears to be most striking about the above transcripts relating to Oonaugh is the array of controversial aspects of

her current situation (ie. family issues, current accommodation, sex, implied 'menial job', no boyfriend and so on). Ostensibly, nurses completed an admission interview with Oonaugh which may have been the source of some of the 'details' conveyed in the above excerpts, as well as, a 'social history'. A social history (a page of questions with accompanying blank spaces for patients to independently answer and comment further as they wish) is typically given to a patient to complete, is then returned to nurses which they add to a patient's chart for reference purposes (ie. Nora and Tina refer to Oonaugh's social history during post-group). Nurses employ this 'tool' to access information which patients may find difficult to talk about (ie. sexual and family relations).

In Oonaugh's case, I suggest that nurses' approach is circular and self-sealing but cross-links with Baudrillard's (Gane, 1993; Baudrillard, 1988) discussions of cultural capitalism. For Baudrillard, the construction of a space is used to build upon what is accredited to be within that space. An inward gaze and concentration of efforts leads to the creation and to the expansion of components deemed to constitute that space. These components are built upon and the effect is an expansion of the former unconstructed details. Similarly, based on little apparent information from Oonaugh, nurses easily raise issues about Oonaugh. Not least of which is that she has already acquired the 'nick name', "Miss Perfect" from nurses.

Saferstein's view of 'collective cognitions' arises from a different starting point than the one that nurses portray above. He suggests that 'experts' bring with them, from their respective domains aspects of how to improve the ultimate television production. Contrasting with Saferstein, nurses delimit their view of Oonaugh with partial pieces of information and exert an inward gaze.

I now turn to present ways in which nurses' discussions can be further characterized and their apparent effects on day-to-day practice. Such characterizations will be subsequently 'tested' with examples from nurses private productions of patients. The first way I discuss nurses conduct during kardex pertains to informality.

An enacted strategy: nurses practice informality

Nurses work during face-to-face contact with patients contrasts with nurses work with other nurses. Nurse-to-nurse interaction displays informality. Wolf (1988b; 1989) suggests a similar characterization of nurses' change of shift report. During kardex nurses regularly joke and laugh with one another. Nurses spend a great deal of time at this type of work. I suggest that it is work that nurses enjoy and even linger at. In contrast, Wolf's view of change of shift report suggests nurses are brief and concise. In the psychiatric ward such forums display nurses' actions as competent historians, story-tellers, and the brevity of their talk is immaterial to understanding what is being transacted or to appreciate the importance of this activity. Thus in terms of 'talk', there is no merit in being concise which in this sense parallels Saferstein's analysis of collaborative work practices. The informality of nurses' discussions are suggested by nurse Iris:

> Iris: kardex we just sit around and we discuss all the patients on the ward. Like, draw from each other and make suggestions to each other, that sort of thing.

I suggest that this informal approach enhances flexibility through a narrative approach. Informality is also conveyed by another aspect of nurses' conduct in kardex. For instance, nurses illustrate informality in their use of 'nick names' when referring to patients rather than necessarily utilizing patient 'given names'. For instance, 'nick names' such as "Willie" (Willard), "Miss Perfect" (Oonaugh), "the [patient] therapist" (Ginger) and "Wino" (Ret) are used during their talk with one another. The use of 'names' enables or is a means through which nurses create an identity for each patient. According to anthropological studies, such naming is part of the ritual of transformation of identity. Cohen (1990) states that "naming as a ritual [is a] means of initiating the person into an identity, explanations of which almost invariably privilege the social definition of the individual over his/her self concept" (p. 2).

Following Cohen (1990), nurses' use of nick names enables them to achieve a sense of familiarity about patients. Cohen draws from Levi-Strauss who suggests that naming "is a presence, but not yet a member" (1990, p. 3). It follows that, "naming is required for a society to possess a person, that is, to make that person a member" (p. 3). For nurses, then, naming suggests that they

are becoming familiar with patients in order to ascribe an identity and their subsequent membership status. As noted, Cohen suggests that such identities "almost invariably privilege the social definition of the individual [patient] over his/her self concept." (p. 2). In other words, an identity is imposed upon patients by nurses rather than a patient coming up with a name based on their reflection of themselves. Although this point cannot be pushed too far, nurses informality with patients as individuals displays something about how they perceive of patients. The recipient of the name is taken here as being descriptive such as "Wino" (diagnosis - alcoholic) and "Miss Perfect" ("everything is just fine"). There are implications of such 'naming'; they deny the patients the right (Cohen, 1990) to constitute themselves during face-to-face contacts with nurses. In the case of naming Ginger "the [patient] therapist", nurses view her as dangerously 'doing community' too well.

The flexibility of the narrative also lends itself to nurses' discussions with one another. It appears as though informality (a casual approach) is employed in nurse-to-nurse forums as a result of the absence of patients. Nurses are as 'ease' as they separate out one patient from the next patient inside this work space (ie. patient Oonaugh). Similarly, the informal approach taken by nurses enhances the way in which they 'get to know patients' with one another. I suggest that these separate constructions of patients recursively reflect and reproduce nurses' claims that patients are handled 'individually' in this site.

"Story" as a key term

Nurses employ the key term "story" to describe "kardex". When considering the expression "story", it is also fitting that the conduct of such work be examined by other components of a *story*. For example: story-tellers; competencies of the story-tellers; and the documenting of a story. These components of story will be used to help examine nurse-to-nurse talk inside this setting. For example, I will show how nurses construct a story for each patient. In turn, as *story-tellers* nurses perform different competencies of a story-teller. Some of these occasions are explored in order to identify story-

telling abilities (competencies) of nurses. I aim to show how the act of story-telling reveals integral aspects of nurses work.

The following strip of interaction exemplifies how nurses, Alison and Jody, associate "story" with 'kardex'. They are sitting at the nursing station at approximately 1250 p.m.:

Alison: Should we go do a story first?

Jody: I suppose.

Earlier recorded comments between Alison, Jody and other nurses were related to "how slow" this particular duty shift is and nurses were discussing the possibility of taking an afternoon coffee break which is atypical for nurses on this ward. Alison's expression "first" in her question to Jody, suggests that a "story" occur first and then nurses could take coffee breaks. It is important that a "story" time occur. Alison and Jody move to the conference room (enclosed glass room central to the ward). In this case, a brief interaction reveals that Jody understands what Alison is referring to by her use of "story": the activity associated with "story" carries from Alison to Jody which suggests an understanding is shared between these two nurses.

The expression, story, also has an effect on other nurses in the general vicinity (at this particular time of the duty shift) in that, together with Alison and Jody's movement into the conference room, other nurses congregate in the standard location for kardex. The practice of 'doing kardex' or 'doing a story' is a familiar activity for these nurses at this time of day. That nurses associate 'kardex' with "story" suggests that nurses are knowledgeable of the 'story-like' qualities of their activities during this period of time together, kardex, discussing patients. Importantly, I am not suggesting that the collective association and movement of nurses adds security to the knowledge produced during these private work spaces of nurses. It is important to suspend belief about what such practices accomplish. However, this routine and collective activity does illustrate that nurses, at some level, relate what they do during kardex to a story. If they did not understand such an association they would use a different term to mark it. In this respect, I suggest that the notion of story compliments earlier suggestions that 'informality' characterizes nurses' descriptions of the practice of kardex.

Methods employed to construct a story

Given that the production of a story for each patient is sought after, it is also important to elucidate how such a production evolves. As already discussed, characteristics of how nurses account for patients to other nurses reveal 'familiarity' and a 'narrative' approach. The organization of each story takes shape as nurses 'toss out' anecdotes resulting in the construction of a workable *story-line* for each patient. For example, Nora and Tina's construction of patient Oonaugh on pp. 188-189 occurs without them speaking with her either in a one-to-one or having read her chart. However, they have heard about Oonaugh from other nurses on the ward and have recently had contact with her during group (ie. "she's the one that wants a boyfriend"). In this case a story continues to evolve among nurses. After a few days of what is referred to by doctors and nurses as "anti-depressant medications", nurses work on Oonaugh to get across what they view as changes that Oonaugh should make. Nurses 'settle on' the view that Oonaugh would likely 'feel better and more independent': if she were living in her own apartment/flat'; if she would find herself a boyfriend; and with a career change she would perhaps meet new friends which go beyond the isolated relationship with her parents. Nurses reduce Oonaugh's current depression to these causes.

Tossing out anecdotes about patients is commonplace for nurses in their talk about patients. One reading of such conduct is that this is how nurses 'dispose' of the details and observations which they may have collected during the course of their duty shifts. For example, by disposing of today's observations, there is a creation of space for details from subsequent duty shifts. In this sense, the narrative is a disposal mechanism for nurses in the production of a story pertaining to each patient. Today's disposal makes space for tomorrow's talk, and so on. Such a process accomplishes nurses' view of patients as individuals. This is similar to Baudrillard's (1988) claim that simulation implies an absence: "to feign to have what one hasn't" (p. 170). In the context of nurses' work, patients are individuals only when they are absent.

Nurse Leona endorses the benefits of having many nurses contribute to a story for each patient when she states:

> Leona: the more nurses the better ... ah, its very nice, get more input and methods of doing things. You're able to, like learning more from one another with varied experiences and you don't get in a rut.

Leona's account emphasizes the enabling aspects of such practices of accountability in that there is more potential for "more input and methods of doing things". Accompanying this however, are limitations of such an approach. One limitation is that for an individual understanding of each patient it seems to me that they are 'washing out difference' in order to settle on a unifying vision of the patient. What is implied is that nurses look to one another (instead of the patient in question) which prevents nurses from "get(ting) in a rut." Nurse constructions of collective accounts minimize individual contacts and hence their team approach absolves them of accountability to individual patients. The danger of a one-to-one accountability (one nurse for each patient) is offset by building a safety net by nurses conducting a collective approach. As a further counterbalance to an absence of each nurse's accountability (one nurse and one patient), it is important to note that each nurse writes anecdotes (they are formally accountable but not in practice) in patient charts corresponding to their patient assignments on a daily basis.

I now turn to further delineate how nurses' accomplish patients in their absence.

Accomplishing patients

A closer examination of nurse actions reveals that one way nurses accomplish patients during their talk is through the use of role-playing. Nurses *recite a patient* instantiating first person speech patterns and by acting out behaviours of patients. Nurses use 'first person speech patterns' which effects a display of a patient. Nurse Tina refers to patient Josh and his experience of memory difficulties:

> Tina: . . . ah, he couldn't remember how to get there, "Like, I can picture it in my mind (hand to head) but I can't remember, you know, (moves hand in air) just how to get there" he said.

This enacts one way to 'play out a patient' and enables other nurses present to 'hear' what a patient previously said. In effect, nurses reproduce a patient to

other nurses using this technique of accounting for a patient in a patient's physical absence. Nurses demonstrate skill at performing and rehearsing such accounts of 'a patient'. In this way, each nurse present during these discussions has the benefit of experiencing that patient. Such performances provide evidence for all nurses in attendance about a patient. That a nurse is able to contribute to the discussion with a first hand account of a patient suggests that credibility (of the performance given) may be increased with the supplementation of 'patient' text. Nurses treat this 'patient text' as valid.

In turn, by nurses being privy to 'patient text', any subsequent approaches by a nurse to a patient enables that nurses, who may have not had a specific interaction with the patient before, to conduct themselves based on "what's happening with all the patients" (see pp. 186-187). Thus a *lived experience* portrayal of a patient is effectively available for other nurses use. Henceforth, other nurses can contribute to a story related to the patient being addressed regardless of their experience in specific interaction. Rose and Miller (1994) suggest a similar process when they claim that therapists "actually act out the marital problem of the couple [being counselled]" (p. 54) for other therapists, to help develop their understandings of particular couples.

Nurse production of patients is also enabled by other aspects of performance. In particular, to the specific use of words or conversation which is transacted (between patients and nurses) an accompanying display of patient actions helps to further illustrate the point being made by nurses. To clarify, while one nurse describes the physical appearance such as "its just kind of droopy . . . just kind of fallen" another nurse picks up on the verbal description and demonstrates the appearance of a patient's tongue with her own tongue. This performance acts to make the 'patient text' visible. In this sense, nurses concern themselves with precision in their representations to one another. To draw from Baudrillard, nurses produce a simulation, as well as, a display. The spectacle becomes simulation, nurses perform 'patients' to one another. In this way, 'the patient' is made visible to, and is 'experienced' by nurses.

As noted, precision of language with first person speech patterns lends credibility to a nurse's performance of a patient. The matter-of-fact tone used by nurses during such portrayals lends itself to perceived 'objectivity' which is

implied to be upheld. Such playing out of patient actions simulates a 'first-hand' representation of that patient for other nurses. Rehearsed information becomes evidence about a patient. Such enactments of a patient constitute evidence of 'objective' constructions that nurses take-for-granted and subsequently operate within. In terms of nurse surveillance practices (an activity of care), performances/simulations provide further avenues for nurses to survey patients. Here, patients are physically absent.

This cross-links with previous aspects of my discussion. Given the regular 'role-playing' of a patient by a nurse to other nurses, something else is achieved, that is, a familiarity about particular patients is produced amongst nurses. Over time the familiarity is sufficient to keep a story of a particular patient going despite the possible absence of new anecdotes. Previous well-performed presentations of patients have a lasting impact. For example, Oonaugh's story as constructed by nurses remains the same during her hospitalization and is reified during her final session in group (see pp. 178-179). Frequently however, the story about a particular patient is kept 'alive' and is nurtured by additional anecdotes, such as face-to-face interaction between nurses and patients. In other cases, such as patient Bertha, nurses did not even need to see her before admission, they already 'know' or have an understanding of her. With such an approach, nurses ultimately create a story for each patient which is partly embellished, but, successfully stitched together in a pattern based on nurses' accounts of their interaction with a patient. It appears as though this process parallels Baudrillard's view of simulation in that nurses "substitute signs of the real for the real itself" (p. 167). These simulations are consistently portrayed using a precision of language which lends credibility to the fabricated story. Further, credibility is also effected by the mutually perceived and measured competence of the nurse telling the story. I will explore particular competencies, but first I introduce Benner (1984; 1991) and Benner and Wrubel's (1988) work related to nurses 'story-telling' and the importance of language.

'Expert story-tellers' and 'novice story-tellers'

Like Benner, I suggest that 'good story-tellers' stand out from 'poor story-tellers'. Benner (1984, 1991) and Benner and Wrubel (1988) base their view of

'expert' nursing practice on competencies of 'telling a story'. A nurse's resources, his/her ability to relate discrepant, contradictory and partial pieces of information are means of distinguishing 'good' story-tellers from 'novice' story-tellers. Following Benner, fluency of language is central to 'expert' practices. She states an "expert is at home with the language" (1984, p. 19). She elicits accounts from nurses by asking nurses to provide a story about something significant in their practice. In this way she obtains a narrative account from nurses. To exemplify what Benner suggests, an excerpt will be presented to elucidate what she identifies as an example of an "expert psychiatric nurse clinician" (1984, p. 32). Benner claims the following account is taken from a nurse who has worked 15 years and is "highly respected by both nurses and physicians for her clinical judgment and ability" (p. 32):

> Expert psychiatric nurse clinician: When I say to a doctor, "the patient is psychotic," I don't always know how to legitimize that statement. But I am never wrong. Because I know psychosis from inside out. And I feel that, and I know it, and I trust it. I don't care if nothing else is happening, I still really know that. It's like the feeling another nurse described in the small group interview today, when she said about the patients, "She just wasn't right." One of the things that I am doing now is getting some in-service in to talk to us about language. But all I am really trying to do is find words within the jargon to talk about something that I don't think is particularly describable (1984, p. 32).

Benner claims this excerpt is about this nurse's "perceptual acuity" and that:

> (t)his nurse is saying that she can recognize the changes common in psychosis because of her 15-year intensive study. And she is probably right. (...) The nurse went on to describe a situation where she knew that a patient was being misdiagnosed as psychotic (1984, p. 33).

A key for Benner is that a nurse is familiar with language and that such 'experts' convey such confidence with others, including Benner.

To consider the possible saliency of what is being claimed by Benner, let me contrast her discussion with Garfinkel and Sacks (1986). Garfinkel and Sacks suggest that 'member' conveys a "mastery of natural language" (p. 163). Such membership accomplishes the individual who is speaking as a 'member' of the organization within which they are conveying an account. The above nurse "expert" claims that I don't always know how to legitimize" a label ("psychotic") "(b)ut I am never wrong". Benner goes on to support this nurse's view of

"misdiagnosis" in a subsequent example provided by this nurse. This suggests a circularity in how Benner accounts for expertise. Benner's interpretation of a nurse's skill based simply on the expression of the 'correct' discourse merely echos the nurse's membership in this site. Surely one could exactly expect some mastery of the language "because of her 15 year(s)" of practice. But connecting this to her "perceptual acuity" remains a leap in the dark. Mastery of language certainly connects to membership and is, I suggest, exactly all that is being safely accomplished during kardex. Munro (1994) emphasizes that, "to say what can be seen" (p. 15) connects with the notion of expertise which underlines a sense of authority (refer to p. 180 for previous comments).

Membership work, nevertheless, has its effects. As already noted a nurse's performance of a patient has consequences for a patient's identity as individual. Drawing from an example of patient Duncan I will provide a contrast to Benner who takes a nurse's story as evidence of 'expert' and good practice. In other words, I problematize nurse's language and its effect. Although Benner assumes that 'mastery of language' distinguishes experts from non-experts, as will be shown, only through cross-checking nurse practice can an examination reveal what such competencies produce in day-to-day practice. In addition to elucidating nurses' competencies of 'story-telling' (and narrative approach, informality and story) in the following ethnographic material, I will introduce further aspects of how nurses accomplish patients' performances during kardex.

Nurse competencies

An examination of nurses' discussion reveal further competencies of nurses in constructing a story about patients. The following 'internal' account of day-to-day practice reflects a 'story-line' which is convincing and one which lasts. Also, competent nurses will be shown to be able to establish story-lines which accommodate error and a range of details. In some cases, nurses laugh at their own constructions, even when they may turn out to be inaccurate. Errors to stories are freely admitted in the privacy of nurses' work space and concealed from persons located in the public spaces beyond such nurse practices in this ward. I suggest that, if researchers do not access this particular work space such

practices of work will be overlooked. A distinction between an 'internal' and 'external' audit, will be revealed by two separate issues around the production of a story about patient Duncan. First in the private space, 'how' particular details are productive for nurses in catalyzing an account for a particular patient is shown. Second, an extension of such a fabricated construction is used to cover up what happened to patient Duncan and an account is relayed to the public space, a family member.

The initial discussion amongst nurses occurs during kardex at approximately 1:00 p.m. Nurses discuss patient Duncan in the typical fashion in that, his name is called out from the kardex registry and the 'tossing out' of anecdotes about him begins:

Jody: Duncan?

Samantha: Sleeping.

Amy: Is he getting better?

Jody: Ah, well he was in bed, there yesterday, but they changed from Librium to Largactal one hundred at HS PRN and it was, and they weren't going to give it and it was in the tray and they gave it by mistake instead of holding it (laughs) and he hasn't woken up yet.

Nora: He's still sleeping?

Tina: He's still sedated eh?

Samantha: Yeah, he was, you know he will just sort of open his eyes (closes and opens eyelids to demonstrate) but he will just kind of roll them and go back to sleep.

Jody: He isn't having any back pain or headaches right? (laughter in room)

Samantha: No

Jody: and he hasn't voided all night and he hasn't voided on our shift (laughter in room). And he's for a ah, cookie swallow, the speech pathologist will be back tomorrow.

Amy: Does his wife ever come in?

Jody: I haven't seen her.

Nurses appear to treat this situation as amusing. In the above example Amy registers concern in one domain asking "(i)s he getting better?" while Jody and Samantha illustrate that it is difficult to assess any possible improvement in light of the knowledge that "he hasn't woken up yet" as Samantha displays Duncan as tired (ie. closes and opens eyelids). In particular, Samantha, Jody and Nora infer that his current state is one of tired in their use of words such as "sleeping", "hasn't woken up yet" and "sleeping" respectively, while Tina suggests he is "sedated". The movement between 'improving health' and 'sleeping' is amusing for these nurses. Fernandez (1986) discusses "amusement" arising from talk when there is a shift from one semantic domain to another (p. 96 and p. 91). He refers to this in terms of 'metonymic associations' and indicates that emotion emerges from shifting between semantic poles. Fernandez suggests that "a sufficiently clever person can make out a strength in any frailty and a frailty in every strength" (p. 85).

Above, Jody raises the matter that Duncan has not voided and accounts for the absence of urinary output as a result of his current sedated state. Nurses freely acknowledge the cause of Duncan's sleeping is that "they gave it by mistake instead of holding it." In this private work space nurses freely identify a medication error. From the nurses' perspective, Duncan's current behaviour is acceptable given the knowledge that the medication error has 'caused' prolonged sleeping. No further intervention or discussion occurs as nurses have determined that he is sleeping and although it is a long time to sleep (approximately 16 hours) they can account for his behaviour which is understood to be induced by nurses' "mistake". Kuzmics (1991) examines embarrassment and states that "the successful maintenance of a front is tied to the successful avoidance of embarrassment" (p. 7). I suggest that nurses avoid embarrassment as they stick together and settle on a collective account: a mistake which apparently absolves them of any further action.

Nurses laugh about the absence of "back pain or headaches" in Duncan's current state. The gist of this strip of interaction during kardex appears to be 'this is what happened and nurses will wait for the medication to wear off'. Goffman (1972) suggests such a state can be described as at 'ease'. The laughter suggests that these nurses are not worried about Duncan because they can

account for the situation. Nurses normalize the situation of Duncan's presumed absence of urinary output and backpain (although this seems a bizarre thing to ask about given the circumstances) due to his present state of sleeping. Kuzmics (1991) suggests 'calculating rationality' delimits potentially embarrassing situations. Nurses' view this situation as non-problematic and laughter enables their ease. However, as will also be shown, the ease of handling this internal view of acceptance, is challenged as persons external to this locale 'happen to' call for an account from nurses.

As the above example illustrates, from the nurses' perspective no harm is done to this patient. The next move in the above strip of interaction occurs when nurse Amy inquires about Duncan's wife. This may occur because nurse Amy was associating the current situation with how nurses might explain this "mistake" to an outsider, such as a 'significant other'. Amy may be considering potential repercussions for nurses' actions in this situation. Alternatively, Amy may be inquiring about whether or not Duncan has a wife and inquiring in a manner which does not reveal her (un)familiarity with Duncan through kardex.

Details pertaining to patient Duncan arise later during this particular kardex as an account is requested by a person external to this discussion. At this time, Tess, a Ward Clerk, enters the conference room and inquires "what do I tell her" in reference to Duncan's wife who is on the telephone:

> Tess: (enters conference room doorway and stops) Duncan's wife is on the phone, what do I tell her how he is today? (laughter in room) (laughing) I wasn't quite sure what to say.
>
> Jody: He is resting comfortably. (laughing)
>
> Tess: He's resting in peace.
>
> Amy: No not yet, I
>
> Tess: or does someone want to talk, I'll transfer her. Does someone want to talk to her? . . . . . .
>
> Nora: Just say he's been tuckered out all day, slept through the night and (laughs) most of the morning
>
> Tess: "He was really tired today". Did he have a good night? (laughing and Tess leaves)

Tess asks for assistance from these nurses when she enters the room and projects some uneasiness as the person speaking to Duncan's wife over the telephone. When Tess says "(h)e's resting in peace" she makes a pun which rides on Jody's previous comment. Amy picks up on "resting in peace" and suggests 'no he is not dead yet'. Tess attempts to assert her position to the nurses, however, they did not talk to Duncan's wife themselves. This evinces an instance of nurses' power over an auxiliary worker such as Tess, as nurses are 'busy' (Melia, 1987) doing work in this kardex session. I suggest that amidst nurses' important activity of kardex they are not easily disturbed.

Despite Tess's offer to transfer the telephone call into the conference room for nurses' convenience (nurses would not have to physically move), this is dismissed in the empty moments of silence in the conversation following her question. Here, Tess, Ward Clerk, is left to relay partially omitted information about Duncan's condition and likely reasons for his sleeping, to his wife. At this point Nora offers her suggestion to inform Duncan's wife that Duncan has been "tuckered out all day, slept through the night and most of the morning" which she could not convey to Tess without accompanying laughter. Tess also asks "(d)id he have a good night?" for which she does not receive, nor wait for, a response to. I suggest this interaction shows how a fabricated and collectively agreed upon account is produced among nurses. In Benner's words an "expert is at home with the language" (1984, p. 19).

Duncan's present condition, induced into sleep, for an extended period of time is accommodated in nurses' construction of a story about Duncan. In addition to the nurses fabrication of a story as relayed to Duncan's family member, this example also signals nurses' 'power over' Tess, Ward Clerk. I suggest that this reveals how nurses rely on their hierarchical power over Tess. She is left to convey this newly constructed information to a family member and nurses can rely on her to talk to this particular relative without revealing internal mistakes. Kuzmics (1991) suggests that the more "powerful a partner (ie. nurses), the less need he worry about the opinion of others [ie. ward clerk] and the less likely is it that he will become embarrassed" (p. 24). Following Kuzmics' view the more superior hierarchical level of nurses in relation to Tess suggests that, nurses do not worry about Tess's opinion who is knowledgeable

and has been privy to the above interaction. Such a relation also applies to Tess as a member of Bestcare, and Duncan's wife who is further detached from the production of day-to-day practice on this ward. This example represents the construction of a story which accommodates error and reproduces competencies of nurses both internally and externally to this ward. The emphasis on a united front of nurse action is sustained. The account provided by nurses here is on behalf of another nurse who worked the previous evening duty shift. Embarrassment is warded off and the continuity of competent nurse action in this site is upheld.

Further consideration for Tess's position is that, she is now implicated in the production of the story. Tess is displaced by nurses' 'moves' and has a choice to come back with a counter-move which may then displace nurses (ie. Tess could be an advocate for Duncan). However, the hierarchical power which nurses perform (over Tess) is apparent as Tess offers (what appears to be implied), what she understands as the story of nurses related to Duncan. Such acceptance also evinces her "mastery" (Garfinkel and Sacks, 1986, p. 163) and membership to this ward in particular ways rather than others.

This particular situation overlaps with Arndt's (1993) thesis which focuses on nurses' medication errors. I suggest that nurses' account of the above medication error contrasts with her contemporary examination of medication errors in important ways. Medication errors appear to be handled more casually than the procedures identified by Arndt's discussion of British and German nurse practices. Although the standard mode of practice in Bestcare is purported to be that an "incident report is filed for any medication error" (based on documentary sources and nurse interview accounts) the above incident went 'virtually', un-noticed. Arndt also relies on interview accounts to show that guilt and shame are two emotions associated with a nurse acknowledging a medication error. She discusses how nurses say they manage to cope with the experience of having made a medication error using both 'guilt' and 'shame' to pin down her interpretations of nurses' accounts in her study. Arndt's discussion is alluring but is constrained by possible understandings which rest on retrospective accounts of nurses and *a priori* views. One of Arndt's aims is to show how shame and guilt are experiences of

nurses who make medication errors in the administration of medications to patients. The circularity emerges when she suggests that 'shame' and 'guilt' are the terms nurses use in interviews.

In relation to nurses' treatment of Duncan, nurses 'cope with' the knowledgeability of a medication error with amusement, laughter and jokes which conceals any possible 'shame'. The 'collective of nurses' is not divided over this error. This case underlines the importance of including day-to-day practice in research studies. The example of Duncan reveals that ways in which medication errors are handled by nurses are distinguishable. In Duncan's case, the consequences for nurses co-producing a story are uncertain. However nurses produce an account of Duncan which satisfies them and is used as an external account of nurses' competency and awareness of Duncan's condition. As already noted, familiarity, informality, a collective approach, and 'acting out' the patient enhance the narrative approach employed for the creation of this account about Duncan. Rosengren and DeVault (1963) suggest that private areas of wards are employed by staff "where the costs of 'mistakes' are decreased" (p. 290). Nurses make use of 'first person speech' and rehearse Duncan for the benefit of others who have not had contact with Duncan. Despite Duncan's absence, nurses are now familiar with Duncan which is the effect of their inward gaze and cultural performances.

Constructing a story and transforming identities

Other nurse competencies emerge from their discussions with one another as they construct a story. I will explore another example of nurses' work space while discussing a different patient. As before, nurses' talk is productive for them. However, in this case I would like to show how nurses' work with a story-line which can both, accommodate errors and sustain the potential for expand-ability. Such elasticity enables the introduction of further anecdotes about patients as nurses contribute or 'toss them in'. The elasticity of apparent story-lines lasts throughout a patient's hospitalization. I suggest that this **motility** adds a sense of stability (refer to Chapter 2 and p. 234 for further discussion on motility). Amidst a constantly changing setting (new-patients,

different nurses, varying lengths of hospitalization, and so on), the ethos of story-telling creates the feeling of having some control over practice.

In the following example, nurse Tina poses a hypothetical view about patient Stella to other nurses which acts to initiate a new line of discussion and charts out an accommodating direction for the construction of a story. The following strip of interaction, also articulates how nurses talk about patient Stella in the production and understanding of her identity:

> Nora: Stella slept OK. She was up at six. She slept alright but was still tired. She went to AM activity, but didn't do a lot. We gave her no choice.
>
> Leona: She did a lot of sighing there. She participated and did OK, but there was lots of (demonstrates sighing noises; inhales and exhales loudly; three times).
>
> Tina: I get a feeling of hostility from this lady.
>
> Leona: She's angry about something.
>
> Nora: I think she's . . she's really manipulative
>
> Tina: Yeah, she's quite manipulative, I think. Like, I talked to her about group yesterday. I mean, I'm sure she'd be just lots of fun in group [as if Tina did not want to invite her but recognizes that she is suitable for group], but my idea is that she's going to sit here until he [husband] feels guilty enough to come back home. Like, I don't think she sees that she's is in here for herself. I think there's a lot of manipulation myself.
>
> Nora: I noticed that a lot yesterday.

I will unpick this excerpt carefully. Nora begins talk about Stella 'tossing in' anecdotes which suggests that she is aware that Stella "was still tired" although she "slept OK". "She went to AM activity, but didn't do a lot" which Nora implies is reasonable or at least not objectionable in that, this is associated with "slept OK".

In line with previous chapter discussions, this example underscores the importance of Stella's physical presence for nurses at this activity as evidenced by nurses' approach with Stella in "(w)e gave her no choice". The tone of this expression also illustrates the posture nurses employ to gain 'power over' Stella in their effort to obtain membership by having Stella enrol herself. Nurse Leona offers validation to Nora's implied view that Stella was not happy about

attending this community activity in "she did a lot of sighing there" which is followed by an accompanying display of sighing noises.

Tina is reading Leona's performance and making an interpretation; the evidence is the sighing. Tina uses this to supplement her "feeling of hostility" from this patient. This elucidates how and what is being accomplished. I suggest there is an analogy with Fernandez's (1986) discussions of Spanish childrens' efforts toward identifying with animals by acting out their mastery over them: [2]

> They fully become subjects, that is, themselves, by becoming masters of animals. The identity process by which the youth becomes first an object and then a subject is seen in the games of *a caballos* and *el xugo* as over time cows become drivers and horses and wolves become riders. It is seen as an enduring dialectic in *a la morena* as the boys become the *burra* and then the master and then the *burra* again. (...) which involves basically an understanding of how we master these predications - how we move, that is, from the preoccupation with the predicate back across the copula to an understanding of the subject and its difference from the natural world (p. 35).

Here, the children "subject" themselves to the game thus making them 'selves' (subjects) and in doing so, become masters of animals. This clearly underlines the duality of 'subject'. Drawing from Fernandez, above Leona 'acts out' or performs Stella (in her absence) with the accompanying sighing noises for the nurses present. These accompanying actions reflect the practices of Spanish children to "master the animals" by becoming an object (demonstrating) and then a subject. As noted previously, nurses' actions to simulate patients as frequently as they do suggest that they are not satisfied to 'talk' about a patient but they happily perform patients for one another.

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[2] "In the game of *a la morena* one boy plays the role of a female donkey (*burra*), bending over while the others leap-frog over him in a series of challenging ways until someone touches him with a foot and must then assume the position. Here there is struggle to avoid taking the position and to prove physical skill. But one notes as well that the younger boys assume the position readily, and very young children bend over happily for long periods while others practice leaping over them. Perhaps they do not fully realize they are taking the position of a *burra*. Yet two- and three-year-olds passing the summer months in the caserio in the mountains will spend hours playing at *xeta* (calf), swinging and nodding their heads as if they were cropping grass or collared with a ball. When they are a bit older, they will play at cow and milker with their older brothers, one assuming the position of a cow and the other milking him and then reversing roles., The animal play easily translates later into the horse, cow, and wolf play of the schoolyard" (p. 34).

Leona continues to speak about Stella stating she "participated and did OK" which supports the view that physical presence at community activities is what counts for nurses, and that Stella is cooperative. Stella is reported to have been capable and, competent at demonstrating her self-discipline as a patient. In this case, Nora's original statement (ie. "She slept OK. She was up at six. She slept alright but was still tired. She went to AM activity, but didn't do a lot. We gave her no choice") about Stella contains specific 'bits' of information but, is not sufficient to keep a discussion going. Leona's comments confirm Nora's but another speaker, nurse Tina, moves the discussion on further. Tina successfully identifies a story-line which is capable of accommodating further anecdotes about this patient. Tina is a competent story-teller.

In this regard, the key move in the above transcript occurs, "I get the feeling of hostility from this lady" which sustains discussion. This statement places Stella in association with an ambiguous label (hostility), however, one which nurses can work with through their talk. For nurses, talk about patients is work (to 'do nurse' is to talk about patients) which assists nurses to go on with their work related to a particular patient. Tina's notation provides Leona and Nora with an opportunity to offer further comments in a way that valorizes Tina's view. Leona and Nora are able to 'toss in' ideas about "ang(er)" and "manipulat(ion)" which are suggested to be congruent with "a feeling of hostility" and the talk about Stella continues.

In contrast, Nora's initial comments about Stella were not as 'workable' as Tina's competent conversation starter in establishing a line of conversation or story-line about Stella. Nora's statements were 'non-starters'. Tina's interpretation of Leona performing Stella through "sighing" produces her identification of a label (hostility). A story-line takes shape through nurses talk. One comment, in turn enables other nurses to enter and add to talk about Stella once "hostility" is expressed as a problem. Importantly, Tina's use of the label "hostility" successfully opens up discussion rather than closing discussion down amongst these nurses. In the absence of comments conflicting with such a statement, the label "hostility" sticks thereby, punctuating nurses' settled view and one which they take as representative of Stella. Essentially this speculation during nurses' talk accomplishes a working understanding of patient Stella

which nurses now treat as though representative of her person/actions. In this way, nurses' performance of Stella transforms her identity and creates a view of how they will subsequently approach her. Nurses are detached from patients but are able to create them: a production of performances. 'Sane' nurses construct a version of 'mad' Stella, one which pre-figures that she will, although reluctantly, be allowed to 'do community'.

In Tina's second turn of this discussion she sarcastically/mockingly states: "I talked to her about group yesterday. I mean, I'm sure she'd be just lots of fun in group" as though this was an activity Tina felt she ought to recommend to Stella. This indicates that Tina perceives Stella to be a suitable member for the group and suggests that group might be useful for Stella. As previously quoted, during an interview with me Tina describes patient attendance at this group as one which is based on "suitability":

> Tina: (...) It varies according to the type of group you do. Right now it is a psychodynamic group. They are not in crises but they are able to take in some information, they are not psychotic. Uhm motivated to work on interpersonal aspects ... people that wouldn't fall into that category fall into a different group. Able to take something in, listen and take something in. Those that, don't, aren't for example preoccupied with their own thoughts, ah.. not taking in information, not the motivation.

In terms of Stella, however, earlier Tina suggests that it may not be "fun" for her (as one of the nurses in group). Hence, despite being a possible group candidate Tina continues talk about Stella saying, "but my idea is that she's going to sit here until he feels guilty enough to come back home" in reference to Stella's husband who had apparently moved out of their home at the time Stella was admitted to hospital. Such a statement implies that 'there is little that nurses can do' the real issue is one between Stella and her husband. I suggest that Tina is saying that Stella has her own agenda and therefore Stella is not suitable for group. In this sense, nurses do not justify Stella for group membership. Such a view emphasizes how membership is not fixed and that patients can be added or dropped at any time.

The former statement also implies Tina's view that, Stella is "manipulating" her husband, in addition to the nurses on the ward. Now Stella is branded as a "manipulating" patient which acts as a signal to other nurses (see Rosenthal, et. al., 1980 for discussion of problem patients, pp. 25-50).

This term sustains defining features of practice in this work setting while embracing both aspects of ambiguity and stability. Such branding of a patient accomplishes two other important achievements. First, the label provides an axis around which other descriptors can be attached and accommodated. A nurse's resources, his or her ability to relate discrepant, contradictory and partial pieces of information are means of distinguishing good story-tellers from novice story-tellers. Second, branding a patient with a label acts to reduce the patient to that label. These reductive accomplishments represent important confirmation devices for the constructed identity of patients which validate the transformation process for nurses. Reductive approaches (pre-figuring of persons as patients) also complement wider organizational practices at Bestcare.

Importantly, this example also conveys that in nurses' view, patients have responsibilities to do some work. In this sense, above, nurses construct a story about Stella. This story elucidates nurses' view of work to do on a patient and they distinguish that which they will get involved with from what they will not get involved with. Nurses settle on a view which directs their subsequent approaches to patients. Nurses will handle Stella with her 'manipulative tendencies' (evidenced in her behaviour) but they have agreed that this is 'her problem'. Once nurses produce an understanding about patients this is passed over to patients. A patient's work is to deal with the problem(s) that nurses identify. How nurses expressed this approach during interviews with me is a matter to which I now turn.

Commonplace expressions from nurses are that "it's the patient's responsibility to do the work". For instance, nurse Zana makes this point:

> Zana: its the patient's responsibility, nobody can do that for them, they have to do it. We can tell them but they need to make the changes...take the responsibility (...) For the patients taking responsibility, they have to want to be helped. Most patients that come in to the hospital want to be helped ah, some are brought in by their parents so if its an adolescent it is harder to get through to them if at all, so sometimes they have to go through recurrent admissions, go through it a second time to actually see the reality of them being here and needing help ah, and also we can go through that with adults as well. But most adults that come in want to be helped, some feel that we're going to help them and we have to let them see that they are willing to do it themselves, like they have to have the want , like they have to have oneness on themselves, to want to do it themselves first, before we can help them. Like we can

> help them , suggest and show them ways of going about it but they have to be willing to do it themselves.

In saying "we have to let them see that they are willing to do it themselves", Zana infers that patients "have to have the want" to see themselves through nurses' 'eyes'. I suggest this is precisely what the process of translation entails for nurses to translate nurses' wants into patient needs (detailed in Chapter 5). Zana notes that for some patients 'getting them to see themselves through the nurses' eyes' requires more than one admission ("recurrent admissions") to hospital. As Zana notes, this is "the patient's responsibility (...) we can tell them but they need to make the changes... take the responsibility".

The above examples show that nurses accomplish a collective agreement on patients by 'tossing in' confirming evidence for one anothers anecdotes. It is important to note that nurses' interests are located in raising 'confirmations' not refutations (cf. Popper, 1963). This approach enacts a united front established by nurses in privacy. Eventually, nurses' talk about Stella, produces connections between "sighing noises", "hostility", "ang(er)", and "manipulat(ion)" which transforms her identity or reduces Stella to these labels. Tina 'wraps up' her construction of Stella establishing an alert for nurses: "(l)ike I don't think she sees that she's is in here for herself". Tina points to Stella being 'the problem', she is displaying hostility and manipulation and the evidence that "she's going to sit here until he feels guilty enough to come back home" is used to underline Tina's opinion. Tina's opinion is validated as she draws on what are treated by nurses as 'objective' anecdotes. Nurses have produced 'a problem' which they can work on with Stella. Nora, a younger member of the nurses reiterates Tina's view of Stella and the discussion moves on to the next patient registered in the kardex.

In the above discussed way, nurses' illustrate a ritual of naming patients. The ritual of naming is a device for classifying. It is important as a necessary condition of possession (cf. Cohen, 1990). Just as God gives names to all the animals, so, too, the nurses master their menagerie by naming patients.

As already noted, the previous example also highlights Tina's view of day-to-day affairs with patients. What emerges is that her opinion counts. In cross-checking other sources, Tina is treated as competent, and during nurse interviews nurses' view her an expert nurse. Tina's special position as a "group

therapist" (which she discusses above) enables her to sustain this status. Each nurse that I interviewed identified this position as having a special status in this work setting. Also Head Nurse, Naomi endorses Tina's work with other nurses to develop their skill and insight into patients in this ward. These are precisely the dangers which Latimer (1993) and Purkis (1993) question in their analysis of Benner's (1984; 1991) work where nurses' own accounts of what an expert nurse is (or any other category developed by Benner) may be misleading. The same criticism applies to Arndt (1993) who draws from Benner's work in her study about nurses' medication errors where an emphasis on "the need of carers, to be cared for" (p. iii) is developed. Utilizing solely nurse accounts marginalizes patients in favour of nurses' work; this rests on nurses' membership by their own account of what it is.

As shown, competencies discriminate a good story-teller from a novice story-teller and enable the demonstration of expertise on the part of the nurse acting out a patient. Although detached from patients, nurses draw from what is available to build up a particular creation of space. Munro (1994) discusses this in term of 'spaces of representation'. As previously noted, this is analogous to the inward, self-sealing logic which Baudrillard describes. Other nurses can add to the story-line or simply fill in details which 'fit' with the original line of conversation alluded to by a competent story-teller. 'Known' psychiatric symptoms are capable of accommodating a host of details and explanations for nurses which suggest aspects of expertise on the part of the nurse 'acting out' the patient. For nurses, competence is revealed by becoming a patient. The rationale is to join in nurse discussions 'to become a member' to constitute status among nurses. This legitimates 'sane' nurses acting 'mad', as they can discriminate between madness and sanity; in contrast, patients are conceived of as indiscriminate (ie. Bertha). Good story-tellers competently understand a patient identity through performance and they easily move back and forth between 'madness' and 'sanity'. Fernandez (1986) states:

> We never become so confident of the identity of the inchoate subject, however, as to escape such metaphoric predications. Even in supposedly sophisticated societies, men in situations of ambiguity or conflict return to likening each other and themselves to hawks, doves, or owls, dogs or their offspring, donkeys. (...) In uncertain social circumstances, subjects return to primordial

> predications in search of a more concrete object upon which the subject can be fixed. There is an interplay, not only in mythology, but in life, between metaphoric predicates and subjects whose identity they illuminate but who must come to master them. Human social life has long demanded not only that we be hawks and doves or leopards, but that we be masters of hawks or doves. Periodically our mastery slips and we return to primordial predications (p. 36).

To underscore Fernandez's quote, nurses enact the 'slippage' of mastery in order to facilitate the 'naming' and 'identity-building' of patients. This shifting between domains ('sane' and 'mad') has become routinized to the extent that it represents day-to-day activity. It's almost like nurses have 'accepted' that madness in inchoate. They no longer 'struggle' as Fernandez suggests, but in fact, have this "acting out" forum for the expression of what they've accepted as inchoate but continue to practice; "master them [patients]":

> When the real is no longer what it used to be, nostalgia assumes its full meaning. There is a proliferation of myths of origin and signs of reality; of second-hand truth, objectivity and authenticity. There is an escalation of the true, of the lived experience; a resurrection of the figurative where the object and substance have disappeared. And there is a panic-stricken production of the real and the referential, above and parallel to the panic of material production. This is how simulation appears in the phase that concerns us: a strategy of the real, neo-real and hyperreal, whose universal double is a strategy of deterrence (Baudrillard, 1988, p. 171).

In the current thesis, ethnographic material has been provided for the reader's inspection. An important question is what simulation helps to accomplish in day-to-day practice. I have suggested that nurses geographically detach themselves and in such spaces of work further practice 'us' and 'them' distinctions: nurses madly produce patients and constitute underlying differences between these two groups of members. Although the taken-for-granted view is that nurses re-present the day-to-day reality of patients, during their discussions with one another, through simulation there is a blurring of "the real, neo-real and hyperreal" where deterrents emerge and reinstantiate the possibility of madness/mirror the presence of having a counteract. Underlying work is that there is no difference between the real and the referential. Czarniawska-Joerges (1992b) examines the use of budgets in public sector organizations and claims that "there is no clear difference between fact and fiction" (p. 238). It is she, referencing Latour, who suggests that "scientific realism differs from fictional realism by the textual strategy of inviting reader to inspect the source of facts" (p. 237).

Storage: 'the formal' account of practice

The final aspect of how nurses constitute and treat patients as individuals is also an aspect which relates to a story. In particular, a story is documented as 'the formal' account of patients for hospital records. Such documentation enables relay to other members of Bestcare (ie. Dr. McGillvary reads a chart while Nora asks "(i)s that Ret you have there") and can also be returned to on subsequent occasions (ie. above Zana identifies "recurrent admissions"). I have shown that nurses construct stories by collective efforts as they 'toss in' anecdotes as patient names are called out from the registry. Nurses document these anecdotes about in a patient chart and the kardex registry. A patient chart represents the formalized account (hospital record) of each patient.

In the case of a patient's prior hospitalization, charts are readily available and in many instances are sent for upon notification of a patient being admitted. In cases when patients have been admitted to other health care facilities, these charts too, are accessible. The chart is a resource which nurses draw upon during a patient's hospitalization and frequently nurses prefer to have an account of patients prior to face-to-face contact with them (see below). Hence a patient's chart represents a record which is formal, as well as, an instructive and a lasting artefact. There is a cyclical logic to the way a patient's chart is used. The chart is referred to because 'it exists' and 'it exists' because it is claimed as a valuable source of information. This supports Raffel's (1979) examination of Medical records at Mont Royal. A patient's chart is employed to reproduce prioritized aspects of the ethos. As noted, Nora prefers to draw from the chart, a resource, rather than a patient.

As a resource, the chart helps to organize approaches to patients in particular ways rather than others. Nurses visualize patients through existing organizing categories which foreclose on other possibilities. Such categories enable nurses to recursively legitimate the way nurses come to view patients as well as the way in which patients are constructed in nurses' work spaces. Pre-figurement is important. Nurses draw on structures of knowledge to 'see' a patient. Consequences of nurses' practices on patients occur, however nurses

treat pre-figured views of patients as non-problematic. I now turn to an example of nurses' reliance on "old charts" (representation of a patient) rather than privileging a current view of a patient.

Nurse Nora is assigned the task of completing a "marital assessment" with patient Tiffany on Tiffany's third day on this ward. Nora is off duty for Tiffany's first two days on the ward. Just prior to conducting a "marital assessment" (scheduled by another nurse) Nora comments to nurses at the nursing station that "there isn't much in the chart and today is my first day back (...) I don't really like doing these things when I don't know anything". This suggests that what Nora 'knows' and how she can come to 'know' Tiffany is through face-to-face contact which Nora is apparently reluctant to do. This instance suggests that Nora prefers to know 'what she has to work with' rather than dealing with a patient whom she does not 'know' or is unfamiliar with. In this sense, previous experiences of a patient give nurses authority to act as though they have been to a 'certain location before'. This is the view discussed by Law (1986) when he suggests that sources of information are used to facilitate the navigation of Portuguese vessels to and from specific destinations. He discusses dangers which previous ships endured and record and in so doing, upon returning with such information (documents, devices and people) this enables subsequent vessels to be more informed and make expeditious and safer journeys 'as though they had been there before'. Here, given that Nora does not have access to documented (pre-figured) information about Tiffany, she must either fabricate a marital assessment of have face-to-face contact. In this regard, not having access to pre-figured sources cause Nora more work.

Nurses enjoy the benefit of other nurses experiences with a patient which have been recorded, as these contacts are instructive for subsequent contacts of a particular assigned nurse with an unfamiliar patient. This also corresponds to Barnes' (1983) view of 'bootstrapping' as a feedback loop. Specific views require "*priming*" (p. 529). As with a feedback loop, he suggests that, once a view is in place, subsequent inductions hinge on previously noted patterns. Given such 'bootstrapped' inductions nurses happily continue their work on the basis of documented (previous/"old charts") information. In the case with Nora, because Tiffany has not previously been admitted to Bestcare, there are

apparently few recordings in Tiffany's hospital chart and Nora is compelled to get to 'know' Tiffany through face-to-face contact.

Previous recordings and anecdotes are treated as though they would facilitate Nora's work: the chart would act to give Nora something to go on rather than relying solely on patient Tiffany, and Nora's ability to access information from her. However, as will be shown with other patients, at times neither a patient nor their hospital chart is required for nurses to establish their journey for patients (ie. patient Bertha pp. 108-109). Nurses sometimes express their discomfort when they are compelled to come to know a patient through face-to-face contact rather than from formalized sources of information such as a patient's chart. Nurses prefer to rely on sources some distance from patients. As shown nurses employ variant ways to get to know patients.

As discussed, 'expert knowledge' is both enabling and constraining for the day-to-day practices of nurses with patients. Nurses display their competency by drawing on resources in their day-to-day practice. These competencies also reveal the type of contact and resources which are privileged by nurses in this site. These are precisely what Foucault (1977; 1973; 1965) identifies as the dangers of typifications in terms of categories, labelling and pigeon-holing of individuals. Foucault suggests that discourse limit beliefs, values and categories on to others, which impose certain ways of looking upon individuals while excluding alternative perspectives. In this sense, discourse works to legitimate the status quo.

As noted, the combined activities of nurses (nurses' action to role play patients and use of 'first person speech patterns' [simulation activities]) together with the storage of patient stories constitute vivid traces of the way a patient is constituted by members of Bestcare. Investigating the use of these sources of storage about patients reveals that for those drawing from these formal accounts, several consequences and assumptions are embedded in such practices of accountability. As this formal storage source is retrieved a self-sealing pattern of such accounts is also revealed. A patient's story as recorded in hospital documentation sources is potent and deterministic.

There are a lineage of assumptions in day-to-day practice about patient charts including that it is: a legal document; accurate; valid; objective and

scientific. A patient chart is referred to by members of the hospital as a 'legal document' and is taken-for-granted to be accurate (cf. Raffel, 1979). For example, nurse Leona talks about the importance of an assessment she performed on a patient and states: "that goes on his chart, that is a permanent part of his chart, it's legal". By extension, nurses take-for-granted that this 'legal document' intrinsically includes 'objective' and 'scientific' evidence about the patients. However, as one example with patient Duncan implies, 'an incident report' for nurses' mistake will be absent. Moreover, only those with membership to Bestcare have access to this 'formal' representation of day-to-day work.

For-all-practical-purposes (Garfinkel, 1967) nurses claim that a patient's chart is a 'legal document' which is based on objective and scientific information. Such claims thereby 'hold' some inherent legitimacy. This premise thereby enables nurses to further assume that this source of stored information, from which they read, ostensibly about a particular patient, is valid. This also applies to other health care workers including doctors. However, such storage constitutes a standardized procedure for handling each patient at Bestcare. Following Baudrillard, "representation starts from the principle that the sign and the real are equivalent" (p. 170). As the legitimate and taken-for-granted representation of patients, the patient text (written version of patient in hospital chart), is viewed to be the real version of patients. Yet, as shown, the 'formal' account is recorded at some distance from patients. Such a view conveys how networks of activity are created by persons' distinguishable action. Overlapping with Law (1986) I suggest these innovative methods, involve both human and non-human technologies "in a way that maintains their durability, forcefulness and fidelity" (Law, 1986, p. 234).

Nurse performances and effects

Nurses transform patients during the ritual of kardex from a patient to an individual. To accomplish this they create a story. Doing a story consists of creating a story-line for each patient. First person speech enables reciting a patient and making a 'patient text'. Nurses' speech patterns of role-playing accompany an acting out of patient behaviours which helps to complete patient performances. Nurses collective creation of stories includes typical psychiatric

discourse which accommodates a range of details which I suggest elucidates the elasticity of terms. This links with earlier chapters discussion of the centrality of language and suggestions that language structures day-to-day practice.

In private the collective efforts of nurse performances also display their competence. Competent nurses demonstrate a coherence in presenting a patient. For instance, the enacted strategy for the story-line is to 'make it general and familiar enough' to enable other nurses to add to the line of talk initiated. Competent nurses create a story-line which accommodates a range of discrepancies, contradictions and partial pieces of information. In this way the apparent strength of a 'story-line' sustains a large range of details and reveals a competent performance.

Another aspect of a good story relates to the language of the story-teller and effects other nurses' contributions. Key words employed by nurses carry to other nurses and demonstrate a nurse's competence at 'do nurse'. Such actions demonstrate a good command of psychiatric discourse and underline aspects of a nurse's expertise. The competency of 'do nurse' reveals that more practiced nurses: talk more during discussions; re-frame the current story-line which enables longer discussions of specific patients; display more convincing performances of patients; and are those other nurses look up to including the Head Nurse, who identifies "my two best nurses" as those who demonstrate competencies as good story-tellers.

Saferstein (1992) claims that in collaborative interaction participants play out fiction but they do so seriously and tap into one anothers perspectives to enhance the production process. In this sense he stresses the 'being on the same wavelength' and 'avoiding the wrong intention'. He suggests that production practices or instantiations of 'collective cognitions':

> are more than debating forums, action channels or power games. They are opportunities for the collective cognition which is the basis of the working relationships among participants (p. 82).

Similarly, that nurses systematically conduct the practice of kardex and patient performances suggests an underlining productivity for them. I suggest nurses do not conduct themselves in this manner for no reason. Such activities are effective in their work. However in contrast to Saferstein's analysis, nurses' inward gaze or focus on production is based on what they have to draw on

within this location and has an effect of being self-sealing. In particular, an account of a patient is agreed upon by nurses. The inward gaze of this type of nurse work or focus on production, as noted, is based on what they have to draw on within this private work space of nurses. Saferstein suggests that participants consider effects of others not necessarily present during production sessions.

In this site, conditions of knowing a particular patient in day-to-day practice include a: story-line; patient's chart; discourse of the specialt(ies); and can include previous experience with individual patients. This discussion has shown 'how' nurses privilege their performance of patients which they construct at a social and geographic distance from patients. In line with Baudrillard (1988), I suggest that there are risks in unveiling masks of what practices of simulation conceal and poses questions of:

> knowing also that it is dangerous to unmask images, since they dissimulate the fact that there is nothing behind them (p. 169).

Nurses' practice also has effects on patients. As already noted, this is similar to Saferstein's ethnography of production which is "not merely a matter of personal taste or aesthetics" (p. 67). These are not contingent on hierarchical relations of power among participants (ie. producer *vis a vis* sound editor). Rather "they monitor each others comments in order to collectively create a solution that will clarify the scene" (p. 73).

A danger of nurses' work is that performances constrain the presentation of self of patients where 'creativity', 'becoming' and the development of 'the authentic self' are taken-for-granted to be captured through nurses performance of patient. What emerges is that nurses work at mastering patients, the production of them as 'individuals', eclipses a view of a patient as person, in practice. Nurses encumber themselves with organizing practice which effects the accomplishment of identities for patients through 'detaching' themselves in this work space (kardex). Nurses' story-telling is private, but, performances are visible to patients. However, they cannot be heard, only seen. Such privacy, enables nurses to create a private work space: a community of nurses. Nurses constitute membership in Garfinkel and Sacks (1986) sense. They state that "(t)he notion of 'member' is the heart of the matter" which I suggest is

accomplished in this work space by nurses employing a mastery of 'expert language' and 'glossing' performances (p. 163). In this regard, such membership reflects a third work space in which aspects of community emerge. Here patients participate only in their absence. While patients are 'doing community' in the ward, nurses detach themselves from patients and create patients. This work involves performance of patients by nurses. 'Sane' nurses act 'mad' as they master productions of patients in ways which pre-figure who is to be allowed to continue to 'do community' and who is to be kept outside, as in the case of those patients who have 'refused' community.

'Community' acts not only as a resource for nurses, it is brought into being in ways that help to produce and reproduce modes of participation in day-to-day work. Nurses deploy 'community' as a device to detach themselves from patients and so replicate their hierarchical orientation in ways which complement wider organizational practices. What emerges in this ethnography is that devices, such as community, go hand and hand with detachments, such as that of nurse and patient. Difference, at least in the hospital studied, is constituted in ways that also mark a connection (Strathern, 1991; 1992). Nurses make themselves present during face-to-face contacts with patient. Nurses make themselves absent and leave patients to 'do community' and interpret it during times when patients engage with each other. Nurses also make patients present in their absence through performance. Having made patients absent, nurses re-construct patients by replicating patient behaviour for one another. Nurses re-construct patients to accomplish their day-to-day work.

Chapter 8

Discussion of day-to-day practice

Organizing has been projected in this ethnography as a social accomplishment. I have attempted to retain the view that "distinctions in the human world are not naturally given; again, they are products or effects of ordering or organising" (Cooper and Law, 1994, p. 4). In this view, participation and community are products and effects of ordering and organizing and in Chapters 3-7, I explored 'community' as an effect of accomplishing the delivery of patient care. In these chapters, I also show how nurses facilitate patient participation in care activities through employing community as a disciplining device. Although seldom conceived of as so, I have elucidated therefore how participation invokes notions of community. In explicating the relations between patient participation and community, I have investigated patient participation as a part of what orders day-to-day practice and have not assumed that patient participation is peculiar to nurse-patient interaction.

It is worth restating that there are versions of patient participation which reflect dominant views in the nursing literature. In addition to prescriptive, and *a priori* views, I have three concerns related to the expanding volume of literature focusing on patient participation. First, my fear is that authors will continue to espouse more and more techniques or strategies to add on to, or impose on, day-to-day interaction between providers and recipients. The effect of such approaches is that there is a danger of *pre-figuring* (pre-ordering, pre-arranging) practice more than it is currently. Second, pre-established views displace patients and may alter the ways in which, as patients, persons are constituted during interaction with providers. I have already remarked, if patients are organized out in the first place, band-aid (plaster) measures to include them at particular moments and time do little to alter the constitution of care practices. Third, authors appear to overlook the extent to which patients

are involved in day-to-day practice and help to co-constitute the conditions of day-to-day practice (by virtue of them being hospitalized as recipients). Much of this thesis has been concerned with explicating this point. I think this is worth doing since I do not wish simply to draw attention to a point which others might consider, on reflection, obvious, but because, in understanding practice, the conditions surrounding day-to-day practice alter exactly 'how' and 'when' patients become involved.

Organizing day-to-day practice

I now reiterate how organizing is conceptualized in this study which assists in elucidating patient participation in day-to-day practice at Bestcare. Investigating aspects of day-to-day practice at Bestcare has enabled me to shift focus in ways that neither deny the importance of either face-to-face interaction with patient-nurse, or more aerial views of managers and doctors (Read, 1989) nor remain entrapped within the limits of these approaches. By focusing between these two extremes, I have been able to explore distinguishable work spaces of hospital practice. Such an approach has enabled me to investigate variant conditions and effects of the day-to-day provision and receipt of care practices.

Cooper and Law (1994) suggest that "proximal thinking deals in the continuous and 'unfinished'; it's what is forever approached but never attained, what is always approximated but never fully realised" (p. 3). In treating organization as a verb (Smircich, 1983a; 1983b) the bringing-into-being of organizings of day-to-day practice is revealed as other than a 'given' or 'fixed' entity. Detailing such a process makes visible, the production and reproduction of relations across time and space which is how organization is recursively accomplished. As previously noted, Cooper and Law's view that organization is "forever approached but never attained" underlines their ontological position of 'becoming' rather than 'being'. Cooper and Law's discussion concerning 'distal' organization and 'proximal' organizings support how community has been examined in the day-to-day work on a hospital ward. However, organization is constituted through formal and informal practices as well as 'distal' and 'proximal' practices. Administrators' accounts make explicit their

emphasis on formal and distal aspects of organizing. This helps to explain their emphasis on standardization of the delivery of care practices rather than receipt of care. Further, such emphasis underlines how pre-figurement is commonplace in hospital practices.

Privileging 'formal' or claimed 'official' practices obscure the way in which organization occurs in day-to-day work settings. Part of the work which members of Bestcare accomplish is to obscure from their view, any reliance on the 'informal' for explicating how organization occurs in day-to-day practice. By espousing and privileging the 'formal', what occurs is a creation of space for other forms of representations of practice on the psychiatric ward. The theme that the informal produces and reproduces organization is a familiar one. For example, Strauss, et. al., (1963) puts this in terms of continuous negotiation and re-negotiation of order among participants in a hospital. Dalton (1959; 1964) also examines official and unofficial practices of four companies and suggests that unofficial practices figure importantly in day-to-day relations among members of these organizations.

As background to this ethnography, an examination of critical incidents reveals members' efforts to marginalize 'the informal' aspects of organizational practices. In turn, organizing efforts 'detach' persons as if individuals stand outside organizations. For instance, according to Bestcare's organizational chart (see *Appendix 3* and members accounts in interviews, patients are not viewed as part of the organization (ie. patients are not included on this formal document). More importantly, in the day-to-day, practices of detachment maintain patients position 'as outside organization': they stand outside Bestcare. Patients' precarious position constitutes them in addition to the organization, as all but superfluous to day-to-day practice. This echos for example, Rosengren and DeVault's (1963) study of an Obstetrical Hospital who suggest that:

> organization of the service seemed to be geared to cast the incoming patient into a role (...) and personnel of the service [ie. doctors, nurses] behave in the ways which they had learned to expect that they should (p. 290).

Here 'learning' can be viewed as a product and effect of power/knowledge. The work spaces of hospital organizations like Bestcare are pre-figured in that

doctors and nurses "behave in the ways which they had learned to expect that they should" and patients are matched up with ward arrangements, diagnosis and care practices which are viewed to simply occur unproblematically. As a consequence of this view that patients somehow stand outside of day-to-day practice at Bestcare, patients are deprived of the possibility to participate in the construction of the content and process of their care (Volstedt, 1993).

As non-members, their ability to participate in their care, arises only in particular and pre-figured ways. The impression that organizing is a formal process, to be kept distinct from the 'subjective' fractures of persons, is supported by an apparent 'objectivity' of matters such as diagnosis, which are treated as technologies (technologies of representation of patients). The process of translation, from persons making representations to representations making patients, is supported by the way of the 'standardization' of day-to-day care practice. As already noted members of Bestcare, draw on formal aspects of organization to legitimate what they do. Administrative members organize in terms of a particular 'speciality' (ie. Medicine, Surgery) and 'sub-speciality' (ie. Cardiology and Gastroenterology) areas. Patients are then matched to or rather patients are made to 'fit into' pre-established categories by using discrete areas of hospital services. To facilitate patient care practices more subtle translations occur. As shown, in the case of the psychiatric ward, patients are first transformed into 'psychiatric patients' and then become potential would-be-members of the community. This process of translation helps to reduce differences among persons (ie. variant health concerns, age, diagnoses, self-identity, and ranging lengths of hospitalizations) in ways that collapse prior identities into categories such as 'psychiatric patients' or patients with particular diagnoses such as 'depression'. The product and effect of this process of translation is the likelihood that patient health care needs will be constructed on the basis of what Bestcare is pre-established to offer.

These translations reflect aspects of reduction and standardization. Administrators presume that 'formalized' organizings direct other members of Bestcare (ie. doctors and nurses) in their daily contacts with patients. Formalizing practice for other members of Bestcare constitutes a large majority of administrators daily work. In this sense, organizational efforts act to 'replace

discretion with certainty' (Dalton, 1959). Such standardization is aimed at specifying ahead of events what will be 'included' and the effect of reductive organizational practices is to accomplish a sense of stability for day-to-day work practices of members of Bestcare. The implicit assumption is that patients benefit from organizational practices. For example, administrators and doctors presuppose that the provision of care converts 'automatically' into the receipt of care by patients on the ward. I suggest this arises from a traditional, hierarchical view, a 'distal' view, one which relies on formalizing practice and obscures the work which accomplishes the receipt of care.

By way of examining practices of inclusion, I have also paid attention to that which co-exists with 'inclusion' and that is a simultaneous 'exclusion'. In this way I explicate how the social accomplishment of organization reveals that persons as individuals are detached from day-to-day practice. Reductive practices are also invoked to instantiate/or help to create patient identity (psychiatric patients, diagnosis such as schizophrenia, alcoholism and so on). Members of Bestcare may attempt to compensate for 'washing away individuality' by espousing the individual nature of care each patient receives. Nevertheless, the ward examined in this thesis suggests that an individuation of care practices is infrequently received by patients.

In the above discussed ways, this ethnography conflicts with the modern version of traditional theories of social order which suggest that organizations 'attach' people (entities) together (Munro, 1994; Cooper and Law, 1994). As this study shows, 'community' is employed to 'detach' members rather than 'attach' nurses to patients which suggests a radical inversion. In this sense, organization and community are as much devices for holding people (entities) apart as they are for holding people (entities) together. Holding people apart can be tied to the constituting of persons which is useful in the organizational view and community is a device for denying that (refer back to p. 8 and discussions in Chapter 2). Day-to-day work practices, constituted by members accounts to one another, reveals their work to constitute themselves as different from others. For example, taking a wider view of organizational work practices at Bestcare, the organizational chart (refer to *Appendix 3* maps out each member of the hospital and their relationship to others. As previously noted, such a division

of labour depicts the function of organizing as "not so much to bring things together as it is to keep things apart" (Munro, 1994, p. 11) which underlines practices of detachment. One reading of the organizational chart is that it is a statement of attachment which "is its rational" use. Second, as a statement of difference, and as already noted, divisions represent a division of labour. In this sense, a statement of difference reveals a pre-arrangement, a *pre-figurement* of day-to-day practice (in advance of persons' performing in specific capacities). One of my aims has been to reveal how connections and disconnections are constituted in day-to-day practice of a hospital ward. Community is employed as a device which enables and constrains attachments while at the same time enables and constrains detachments of persons.

Effecting self-discipline

Nurses employ activities of care to accomplish their work with patients on the ward. These activities of care assist nurses to organize patients. Activities of care are highly routinized practices of nurses and include: surveillance, enrolment and the threat of sanctions. Although I detail these separately, it is their combined effect that is important. Surveillance practices of nurses include both 'formal' (doctors' orders) and 'informal' aspects. These practices are legitimated by nurses for the 'protection of human life'. Routine surveillance practices also provide nurses with access to patients. However, largely, such occasions are not used by nurses as opportunities to talk with patients but rather provide a 'check by looking'.

As noted in Chapter 4, nurses make use of panopticon features of the ward to facilitate their surveillance of patients and others in the ward. In line with Foucault (1977), nurses' routine practices of power, in the form of surveillance, help to instil an ever-developing discipline in patients. For example, one way in which I discussed surveillance as affecting patient behaviour pertains to the provision of medications. If patients do not take their medications, sanctions are in place. In practice, once patients *consent* to be hospitalized they are consenting to whatever treatment doctors and nurses recommend during their stay: this implied choice helps to legitimate subsequent 'activities of care'. For example, in effect, medication therapy is

compulsory. While nurses accomplish the provision of daily medications they reproduce a distance from patients by being 'inside the medication room passing out' medications to patients. Patients are instructed by nurses, repeatedly if necessary, to show up outside the medication room at pre-specified times to collect their medication. Patients do not contest this expectation and cooperate with nurses. Usually without being lectured they exhibit a discipline by queuing up for medications with other patients.

Foucault (1977) draws attention to the interplay of two aspects of disciplinary power, a function (to discipline others through a visual surveillance gaze) and a regulatory effect (to practice self-discipline as a result of being exposed to the gaze of surveillance). Patients (by virtue of their admission on the ward) are aware that they may be subject to surveillance but cannot be certain whether they are being surveyed at any particular point and time. Patients act in the awareness of the possibility that surveillance may be occurring. This regularized (routine) exercise of power by nurses (in the form of surveillance), constantly instils an ever-developing discipline on behaviour of patients.

However, 'visibility' in itself might hardly be sufficient to produce disciplined obedience, with patients 'learning' literally to survey themselves as if they are under the ever present and watchful eye of surveillance. Patients also learn to appear as self-disciplined in ways that require them to conduct 'community' with one another. Here Durkheim's (1964; 1972) view of morality as a powerful force overlaps with what Foucault describes as an effect of surveillance. Durkheim's view of morality requires that community members privilege a view of the 'conscience collective' (1972, p. 26). It is the individual's "participation in the collectivity which introduces a stable order into the universe" (Durkheim, 1972, p. 26). For Durkheim, it is through members informed 'allegiance to the collective' that 'community' is sustained. The invocation of community by nurses gets expressed in particular ways so that the form that patient participation takes appears as a disciplining effect of discourse.

Custodial care and minimal care efforts constitute additional nurse contact with patients. On occasion, but much less frequently than might be supposed, nurses and patients have one-to-ones. Typically, doctors responsible

for patients, come and go from the ward during the mornings. Nevertheless, the most significant aspect of day-to-day practice concerns community into which some patients enrol themselves. That a collective entity of patients is economically beneficial to nurses' practices of organization is the theme to be addressed later in this Chapter. For the moment, I now draw together my previous discussions in order to delineate how work spaces are instantiated for community performances.

Community discourse: setting up for production

In contrast to discussions which set out to define community ahead of their analysis, my analysis defers the question of what community is until a clearer picture is established of 'how' community is brought-into-being. The key question is not whether or not community can be held to *exist vis-a-vis* further definition. The project which I have undertaken has been to elucidate 'how' community is socially constructed in specific sites. One way that community is made significant in this ward is through language. Following Cohen (1985, 1986, 1987), the way in which community is symbolically constructed by members displays a rich and mobile construct reflecting their understandings.

Community is an expression used by nurses and patients, aspects of which resonate beyond face-to-face contact of nurses and patients. Utilizing various expressions of community, nurses mobilize patients in day-to-day practice. For instance, nurses competently advertise community with some variation including: morning program; morning activity; group; community; community meeting; and activities. I am suggesting here a view of discourse as disciplining that compliments surveillance and sanction effects. Nurses' employment of community is persuasive for patients. This persuasive device enhances patient participation in day-to-day practice and orders daily contacts between nurses and patients. In face-to-face contacts between nurses and patients, nurses presuppose that community will hold some value for patients; and nurses underline their views that affiliation, belonging and matters of interest constitute therapy and facilitate healing. In this sense, aspects of community are the means through which persons as patients get 'more'/value

from having particular types of relations with others. These aspects of community, as a persuasive device for day-to-day practice will be taken separately. For example, nurses associate community in the ward with "safe(ty) and secur(ity)" and they implicitly suggest that activities 'are good for you' (patients) in: "it gives you a good idea to see how you're functioning, how you're feeling being around other people" (pp. 54-55). During face-to-face interaction with patients (ie. community meeting), nurses announce community as a priority of day-to-day activities on this ward.

Nurses suggest healing is possible through community. However, inherent to nurse interaction with patients is that it is a patient's 'choice' to heal or not to heal. The notion of choice gets across to patients and appears to effect the way in which they talk about day-to-day practice (ie. patient Ginger stresses choice after one week in the ward). Nurses talk with one another also emphasizes how they do not give patients the opportunity to choose as indicated by Nora who states: "(w)e gave her [patient Stella] no choice" (refer to p. 208). Similar to Durkheim's view of community, where an individual's choice should not be minimized, in this ward, nurses constitute community in a way that a patient's supposed choice to attend community activities signals a sense of their commitment to work at healing. One of the ways in which nurses survey a patient's desire to get better therefore reflects Durkheim's view of responsibility in that, a 'collective' implicates people to be responsible and discipline themselves to sustain the 'conscience collective' (ie. Leona's control of patients in group/community meeting in contrast to Nora's control of Eliot). As the way to a return to 'normality' or to 'heal', patients attend community activities which are scheduled by nurses. Drawing on power effects radiating from community discourse, nurses effect patient attendance/ participation. Nurses view activities as an "expectation" and they mark a patient's presence and absence. In this regard, a patient's presence is monitored, passed along to other nurses and recorded in a patient's chart. As already noted, nurses view a patient's presence as their willingness to 'get better'.

The nurses' view of activities as therapeutic opportunities for patients is also supported by documents stating: "(a)ctivities are an important part of your treatment (...) [and they are] a time to express your concerns or seek clarification

about ward rules" (pp. 55, 57, 67, 132). Nurses explain their actions regarding community on the presupposition that it is therapeutic for patients. Nurses also imply that they have little time during which they can train patients about community as a result of other 'do nurse' activities on the ward (ie. patients are expected to do some of the work). Nurse Jennifer (p. 49) indicates that there is a minimal amount of leeway for nurses in their day-to-day activities. Nurse Leona states: "the main contact with patients is during the activities" (p. 56). Attendance of patients is important. Patient Sasha conveys a variety of activities which keep her occupied and those which involve other patients (pp. 49-50). She also stresses a 'difference' in the day-to-day activities in the psychiatric ward compared to "other parts of [the] hospital". She explains some differences as she identifies planned activities, day-to-day chores and contacts with other patients. This difference is 'special': something special is being offered to patients on the psychiatric ward. As noted, I suggest this resonates with Strathern's view of prosthesis where patients are enabled by nurses work to leave hospital with 'more' than they came with. Their understandings of community have been boosted.

The importance of community gets across to patients and they largely, do not contest it. For instance, patient Rory states, "I just more or less do what I'm told"; and patient Ginger saying, "you kind of go along with the flow". Community is important in this ward and patients pick-up on its importance and "go along with the flow". From the nurses perspective they cannot train patients, 'move' them around if patients are not present at activities. Nurses expect patients to "at least play along" and sanctions are in place if patients 'refuse' (ie. "discharge them"). Patients learn that attendance at community activities is important and this message can be delivered by nurses in a variety of ways.

In their interviews with me nurses did not attempt to conceal their use of 'coercion' on patients to obtain their cooperation in attending activities. The aim of therapy apparently is sufficient to legitimate such coercion. For example, nurse Tina draws attention to the important skill of nurses to "precipitate a crises" and that "sometimes it is a gain to see how somebody [nurses] irritates them [patients]" (p. 149). Nurses employ such skills to facilitate patient

cooperation as individuals. As 'therapeutic' value/healing, asserted by (expert) nurses is important, any particular strategy of domination that nurses employ appears to be legitimate, even if such tactics are coercive. As already noted, the distinction between 'healing' and 'therapeutic' reveal matters of interest such as those addressed by Callon, Law and Latour discussed in Chapter 2 (also discussed on p. 246).

Such tactics cast a different light on belonging as an aspect of community. For example, nurses stress attendance and thereby evoke a sense of 'belonging' for patients. 'Attendance' and 'belonging' are employed as disjunct, yet, similar notions in day-to-day practice. To clarify, the act of attending an activity implies a sense that one belongs there. In this ward, nurses determine who will attend and thereby belong. Another aspect of belonging, as constructed by nurses distinguishes between 'legitimate' patients and 'illegitimate' patients. Nurses expect that patients will get involved in activities (ie. "you can't just come here and watch TV kind of thing"). As previously noted, Turner (1985) provides another view of belonging and refers to the notion of the "star group" (p. 125). He points to a multiplicity of social associations to which individuals are free to join. He suggests that where an individual is viewed to be voluntaristic, they can belong to particular groups of interest and that they choose to belong to specific target groups ("(t)his group is one whose goals, values, and personnel come closest to his [/her] ideal model of how human beings should purposively behave" p. 125). This contrasts with my study in that, patients do not really choose whether they belong to community or not: they get enrolled. However, because some patients are enrolled and nurses repeatedly claim that it is a patient's choice to belong (ie. attend activities or not), an ironic sense of choice, in Turner's sense, applies to persons as patients in this particular hospital ward.

The importance that nurses place on attending indicates that there is not much flexibility within day-to-day routines for patients. In this sense, nurses stabilize day-to-day community by organizing particular activities when nurses and patients interact. Ultimately patients may say 'yes' or 'no' to being present at community activities: "it's your choice". However, "it is an expectation" that is put to patients by nurses. For-all-practical-purposes, such an expectation is

taken-for-granted by nurses in that, patients are said to be informed about the activities and attendance is obtained.

The key term is motile

Nurses' language gets picked-up on by patients. The invocation of community gets expressed in particular ways so that the form that patient participation takes appears as an effect of language. Community is transformable in day-to-day practice partly as a result of an inherent 'ambiguity' of the term. In this way, the term is difficult to pin down due to its elusive characteristics. Some ambiguity can be accounted for by the diverse ways in which nurses employ it in practice. Using community to stabilize, and yet, also leave it open to interpretation for patients embodies how beneficial motility is in day-to-day practice.

According to Cohen (1987), the way in which language works is that each person has a unique way in which he/she interprets and 'make meaning'. He states "people cannot strip themselves of their cultural equipment to step socially naked into a neutral space" (1985, p. 98). People (patients and nurses) bring with them a host of 'cultural' experiences which enable them to 'make meaning' (Strathern, 1990; Cohen, 1985) at particular moments in time in daily practice. Importantly, there is no one-to-one correspondence of message sent and message received. The diversity of cultural experience potentiates the instantiation of everyday and 'novel' translations of community in day-to-day practice. This suggests that as community gets taken-up by members and reproduced in their action, translations can be expected which reflect their interpretations.

In presenting the ethnographic material I have paid attention to the potential for nurses and patients previous experience with community (ie. prior everyday understandings which they bring with them to the ward). In turn, I have suggested that previous experience potentiates or makes possible, community's uptake in day-to-day practice. But, once inside the ward patients encounter a particular language of community. In the ward, nurses draw on different (motile) aspects of community in their face-to-face contact with patients. This variety evinces difference in the way that community is

conceived of and applied or translated in practice. Such occurrences reaffirm ambiguity engendered by the language, community. In this sense, 'difference' underlines ambiguity and in turn acts to sustain a fluidity of movement.

Cohen (1985) raises the importance of members 'learning' within the practice of community. In one case he states that individuals "learn and continue to practice how to 'be social'" (p. 15). However, for his purposes Cohen glosses what is to be understood by 'learning'. In contrast to Cohen's glossing over 'learning', I have problematized learning in the hospital by asking: 'What is being learned (taken-up) by members in this site?' and 'How is 'doing patient' accomplished?'

I now turn to revisit the disciplining effects of language which further heightens the sense of community as a motile notion. Here the visual and the auditory senses figure importantly.

Disciplining effects

As already quoted, Munro (1993a) alerts readers to the prevalence of over-stressing the visual metaphor of discipline, in order to locate a corollary, the auditory sense pertaining to discipline effects. He suggests:

> Too great a stress on the visual displaces Foucault's insight on *discourse* as being central to power/knowledge (p. 250).

Munro makes explicit that not all conduct is reducible to surveillance effects of the visual sense. Following Munro, analyzing surveillance simply as a visual effect of nurses conduct accounts for only part of Foucault's emphasis on surveillance. Munro drawing on Ong, goes on to explain that "sight only sees surfaces and that finally it is understanding, not the visual that does the interpretive work" (p. 254). This underlines the significance of taking into consideration other conduct in this ward such as, discourse as disciplining which compliments surveillance and sanction effects. Nurses language, community, is also disciplining. This underlines the significance of community performances, which are not only visual but auditory. For example, this thesis is largely based on ethnographic material derived from the auditory sense rather than say the visual sense. However, as presented and discussed, the visual sense has also been privileged where possible, as a point of methodology and

one which helps readers. There is a motility. I have drawn on Strathern's (1991) view and Fernandez's (1986) use of 'movement' (discussed in Chapter 2) where he pays attention to the auditory and visual. A limitation of my methods has been to rely heavily on auditory as taken from transcription. The visual sense is noted, but, clearly another means of inducing the transfer obviation of persons is motility, instantiated through movement.

Another way of addressing the important link between what Munro (1993a) alerts readers to in relation to the visual and auditory senses, is in considering language (structures). Structures provide and are employed to provide typical 'moves' during interaction. However, this does not preclude, and instead following Lyotard (1984) leads to displacement practices of 'novel moves'. Over time, discourse is altered to facilitate further spectacular moves. Persons can only represent what is in a visual space through language and in this way, while language is the greatest capacity, at the same time, it is the greatest limitation. As social beings persons construct language to mean certain things rather than others and then apply such understandings to the visual world. As previously quoted, Munro emphasizes how it is important to be able to "say what can be seen" (1994, p. 15). So, the application (seeing) is always after language (understandings) and it is, as Munro says "understanding, not the visual that does the interpretive work" (1993a, p. 254).

In addition to routine surveillance as a portion of what constitutes 'activities of care', nurses provide patients with instructions of 'how' to produce community during face-to-face contacts which nurses have with patients. This evinces the instantiation of auditory senses. That nurses remark on performances they notice about patients to one another suggests that displays of community are being surveyed by nurses (involving both the visual and auditory senses). Moreover, patients are also told that nurses are watching for 'their socializing/contacts with other patients'. In this sense it is not merely an effect of the panopticon which instils discipline in patients to locate themselves in particular areas of the ward, disciplining also occurs in more subtle ways involving the auditory.

Patients translate everyday understandings of community into practice

Once they pick-up on the importance of community in day-to-day practice (through surveillance, sanction effects and discourse as disciplining), patients translate community into day-to-day practice, but, in particular ways. For instance, patients appear to translate everyday understandings of community into practice. Informed by Cohen and Gadamer, however translations can be expected here. Whereas nurses' language frequently identifies community, patients' language provides different versions of community. Patients alternate ways of reproducing community may be explained by understandings which precede their hospitalization, as well as those gained during their current hospitalization with nurses and other patients.

Nurses inform patients of expectations including: 'keeping your room tidy'; 'cleaning up dishes'; 'empty ashtrays in communal areas'; 'take your own tray back to the wagon and get your own tray'; 'do your own laundry'; and 'go up and get your own medication'. Nurses give specific instructions and in this way, appear to reflect everyday understandings of community work. However, that nurses also use multiple connotations of community in their talk (ie. Naomi uses three while Leona uses two different connotations; see pp. 54-55) suggests that the ambiguity of community acts as a resource for nurses.

In turn, patients engage with each other in ways which appear to reflect everyday understandings of community as much as they resonate with those discourse effects from nurse-patient interaction. Patient versions of community include: social bonding among patients during meal times and activities; "belonging"; "having a good time...after you get to know the people"; affiliation; 'hairdressing'; and 'offering assistance with meal trays'. I have shown how patient versions of community are different than those which the nurses provide instructions for. Thus, patient reproductions of 'doing community' are not necessarily a relay of instructions from nurses; they also appear as unsolicited performances of patients in day-to-day practice on this ward. This reveals a sense in which 'extensions' are made in day-to-day practice. That patients perform such actions appears to be a result of the disciplining effects of the language of community (discourse) expressed by nurses. The ways in which

patients translate community in practice (perform aspects of community), reflects how nurses leave open specific ways in which community can be interpreted by patients. This finding underlines community as a resource which I now discuss.

'Community' as a resource

One way which illuminates the significance of Munro's (following Foucault) emphasis on auditory senses (discourse) pertains to nurses' use of community as a resource. Here, nurses make language 'moves' during face-to-face contact with patients. 'Moves' exercise leverage over others and language is used to disadvantage the other (Lyotard, 1984). Nurses deploy community as a resource which enables them to make 'moves' that instantiate community in a variety of ways: in particular ways and at particular times. These 'moves' made by nurses resonate with Lyotard's (1984) view of displacing the other. As previously quoted, he states:

> Each language partner, when a "move" pertaining to him is made, undergoes a "displacement," an alteration of some kind that affects him not only in his capacity as addressee and referent, but also as sender (Lyotard, 1984, p. 16).

Compounded with its effects of 'attaching' patients to one another and 'detaching' patients from nurses, Chapter 6 reveals that community is used to re-direct, silence, ignore and marginalize patient concerns.

In contrast, 'countermoves' are associated with the ability to make 'novel' moves out of the ambiguity of the key term. This ability to generate an array of effects highlights community as a resource. 'Community', like any other organizing structure, when brought-into-being reveals a host of differing effects as patients and nurses create 'novel' ways of instantiating a structure-in-use (ie. group dismissed early). Structures, according to Giddens (1984) are "social practices ordered across time and space" (p. 2). People create and reproduce the necessary conditions to make social practices ordered and possible. Structures for Giddens, exist only in their instantiation.

Ethnographic material emphasizing community as a resource emerges from an examination of community meetings in Chapter 6. Here there is a 'clash' between what patients' understand to be aspects of community and those

of nurses. On these occasions nurses enjoy the ambiguity of this key term which enables them to keep community in play and constitute a functioning network of patients. Confusion and misunderstanding arises from patients when they discover that although community is a shared expression between them and nurses, 'meaning' in day-to-day practice is not shared between patients and nurses. Also, what appears is that patients pre-suppose that community applies to all of their contacts on this ward. However, they learn differently. What emerges from the ethnographic material is that nurses deployment of community, as well as their expert positions as nurses, facilitate them to keep community afloat while maintaining control of patients in a 'collective'.

Finding that meanings are not shared acts to support a notion that a boundary is created between patient work and nurse work: they are created as two separable entities. Exploration of three separate occasions (ie. 'not to be changed', 'valid community issues' and 'planning the week') reveal 'how' nurses handle patients when they test community in day-to-day practice with nurses. In each case questions were put to nurses by patients which appear to be taken up as an irritation and a nuisance. In this sense, nurses treat questions as disruptions to a smooth functioning network. On each occasion, nurses respond in a way which keeps themselves distant from the issue at hand and places the burden of responsibility on patients. For example, nurse Martha performs her competence by placing responsibility back on patients saying: "we don't always get to do what we would like to"; suggests that "maybe you can help if someone new comes in to explain that to them (...) and that that was what was decided" and to "be patient". On this occasion, community is employed as a resource which facilitates moving patients around by stressing the importance of 'stability' of day-to-day affairs. Also, this instantiates that community has some routines and that patients can help one another. Nurses competently relay to patients that which is allowed and dis-allowed in the day-to-day practice of community. As already mentioned, at times, community is marked as therapeutic. Whether or not such activities are therapeutic for patients is not questioned by nurses. However, an enacted policy of following through with plans, is enforced by nurses as though there is therapeutic value

in doing so. Similarly, community as a resource implicates other aspects of day-to-day practice such as rules. For example, some nurses relay the importance of 'rules' stating, "rules are made for a reason and they are not to be changed". Nurses identify potential problems for one another (ie. 'warning signal that patients were upset' see p. 155). I have suggested that such information exchange among nurses acts as a warning signal. In this way, nurses can be prepared to make a novel move if called upon by patients. Language provides a structure within which certain representations stand out and are therefore heard, as problems. In this particular case, the auditory sense appears to be privileged in the day-to-day rather than the visual.

I have also suggested that gaps in perceptions between nurses and patients reveal the different views of what community means for nurses and patients. It is worth repeating that currency for patients in community appears as they instantiate everyday understandings of community: there appear to be particular understandings of community in use. I suggest, patients and nurses are familiar with aspects of cooperation among persons. For example, nurses did try to get rid of 'the individual' in hospital and it appears that only through stepping outside of a pre-figured space of 'the individual' did patients appear to benefit from community as therapeutic (community as a commodity/good and the benefits of some therapeutic value). Also, the importance of currency as a practical and daily accomplishment in this ward reveals community as a currency which is useful and apparently familiar to patients and nurses: it works. In contrast, currency for nurses appears to play upon economic effects, particularly measured by their 'time'. Although expressions of community are beneficial for nurses and disciplining for patients, patients do not contest the relevance of community.

Community: a device which instantiates hierarchy

Paying attention to the social accomplishment of day-to-day work, this study reveals that community is a structure like any other organizing structure which is brought-into-being by people. In this view, the commitment and affiliation that patients develop with one another, and during day-to-day activities, works in the nurses favour. Once community is mobilized, nurses

can draw from and point to patients who are committed to 'healing through community', as a means of enroling other patients. This resonates with Latour's (1987) discussion of a "piggy back strategy" (p. 110) pertaining to a translation of interests where others already enrolled facilitate undecided patients movements (see for example, pp. 59, 71). Nurses facilitate a normative ordering where patients are to turn to one another rather than nurses.

Nurses also mobilize community in ways that require them to treat patients much the same which collapses patient similarities rather than sustaining differences from patient to patient. The discussion here, emphasizing a collapsing of difference, can be reconsidered in respect of Durkheim's view of a 'clan's' solidarity based upon similarity of unity. Durkheim views the clan as a prototype of society in general. Clan members display solidarity "derived from resemblance, since the society is formed of similar segments and these in their turn enclose only homogeneous elements" (Durkheim, 1972, p. 142). As authors such as Wallwork (1972) have noted, Durkheim privileges solidarity (ie. order, stability and equilibrium) thereby marginalizing how 'conflict' affects members of a clan's relations with one another. As shown in this ethnography, an examination of moments of conflict reveals conditions of possibility towards sustaining 'solidarity' of patients by nurses (ie. community meeting). These occasions reveal how nurses draw on particular aspects of community which are sometimes stable (ie. follow through with planned activities) and sometimes ambiguous (ie. varied connotations of community employed by nurses). Community is a moveable feast and nurses skilled moves and countermoves ensure that community is kept in play, in particular ways in day-to-day practice.

Nurses further deploy community as a device to detach themselves from patients and so replicate their hierarchical orientation in ways which complement wider organizing practices. Ouchi (1980), from the organizational and management literature also discusses members of a workplace in terms of a 'clan'. He makes explicit that community ('clan') is divorced from the rules, monetary economics and the hierarchy of authority which typically accompany organization. In this sense he suggests that hierarchy is replaceable with 'clan'/community or that they exist somehow as alternatives. Yet what is

revealed by my examination of the psychiatric ward is that practice which relies on community as an organizing device is riddled with hierarchy. Following Munro (in press), I suggest that it is crucial to note that community is not 'free' of hierarchy. As previously noted, Munro (in press) discusses kinship, an aspect of community. Munro makes explicit how kinship ties are produced among the managers he studied. Contrasting sharply with Ouchi, Munro suggests that community cannot be divorced from the hierarchy as it is brought into being by members who instantiate accomplishments by drawing from it. In a similar vein, Strathern (1994c) questions the peculiarity of suggesting that there ever were 'primitive societies' free of power effects. In this view, 'there is no social life that is not complex', it appears absurd to suggest that community was ever anything else than riddled with hierarchy. Strathern claims that "complexity already exists" and that moves from "the concrete and heterogeneous to the concrete and heterogeneous" more aptly portray 'the real world' (p. 1; p. 3). Munro's view is also conveyed by Strauss, et., al (1963) where they describe how formal and informal practices are part of day-to-day practices in negotiating order in a hospital. They show how both formal and informal practices are important in creating a sense of order in day-to-day practice and that, at times informal practices figure in the foreground while at other times formal practices figure in the foreground.

My ethnographic material illustrates how consideration of hierarchy is germane to studies of community. Community is employed to 'move' others around in particular ways at particular times. As Munro (1993a) states: "(t)o achieve dominance, to displace others towards one's own end, a member has to make a novel move" and community acts as a resource for such moves that cannot stand outside language games (p. 259). Community can never be made immune from power effects but is implicated in its very production. The conduct of nurses and patients instantiate hierarchy by reproducing relations of power both during and outside interaction of nurse-patient.

Nurses do not appear interested in what patients 'think' about community and this suggests that nurses are drawing on community to accomplish other work. Such lack of interest, is exemplified by excerpts from community meetings (discussions where nurses appear un-preocuppied with

aspects of community which might occur outside organized activities; and everyday understandings of community which patients perform versus nurses organizing structure approach). Nurses conduct evinces their deployment of community to detach themselves from patients. Practices of 'detachment' have been identified as those created through distances produced in: discriminations between nurse regions around the ward and patient regions around the ward (segregation); nurses consistent enactment of their expert position in relation to patients; and the distance between nurses and patients during the provision of medication. That such conduct revolves around a strategy of detachment is further supported by evidence of differences between the way in which nurses mobilize community and the way in which patients produce and reproduce community. Nurses deploy community as a device of detachment whereas patients employ community as expressive of the importance of attaching themselves to one another. Nurses' detachment practices make visible to patients that patients are to do the work to heal themselves. It is worth repeating that patients appear to achieve more/value from particular relations with others.

Economy of effort: 'collective' practice

While collective practices make 'visible' some aspects of day-to-day practice, I suggest that collective practices also obscure other notions from view. First I will draw attention to the productiveness of a 'collective approach' which appears to emerge from a functional view of practice. That nurses' privilege a functional view of practice helps to explain some aspects of day-to-day conduct of community on this ward. By functional view I am suggesting that a series of steps are followed in order to accomplish consistent and regular patterns of conduct. For example, schedules for activities are routine and nurses implement these with patients. Other organizational artefacts, such as assignment board and brochures, are drawn on to help legitimate such activities. Instances of a functional orientation can be noted in "the community meeting" registry which is retained at the nursing station for nurses to draw from during weekly community meetings. Similarly, "operations manual", "interventions book" and a heavy reliance on supervised activities exemplify

such approaches in other studies (ie. Bloor and McIntosh, 1990; Shoenberg, 1972; Lennard and Gralnick, 1986). However, a functional view of practice centres on nurses work and marginalizes what patients do: the emphasis is on the provision of care practices.

One wayin which nurses enact their view of patients as a 'collective' is in terms which Munro (1993) describes as 'action in a block'. An 'action in a block' approach to patients sets up an economy which results from, say, one nurse being able to cast a gaze on a group of patients. As one patient 'stands out' from the 'collective' he/she becomes 'visible' to the gaze of surveillance. In so doing, a limited number of nurses are able to manage a 'collective' in a particular spatial and geographical location. I previously identified this type of economy in relation to Goffman's view of the organization of "the large blocks of managed people" surveyed by "the small supervisory staff" (1961, p. 18). For nurses, therefore, there is an economy to their collective practices with patients. In contrast to authors such as Lennard and Gralnick (1986) who accept large blocks of patients as unproblematic, I have examined how a collective is privileged by nurses and its effects and products. As already noted such approaches obscure from view the effects of patients conduct on each other and the disciplining effects of language. Also once patients are packaged as 'a collective', difference among those engaged in community performances are obscured from the view of nurses. This is an effect and function of discourse.

The economy of social accomplishments is specifically signposted as the "efficiency of power" by Foucault (1977) which underscores an economy of effort (pp. 202-203). The economy of effort expands as persons knowledgeable of a surveillance gaze 'take over' this practice (become self-disciplined) demonstrating such action for others who are also exposed to such practices (disciplining effects of discourse). Hence, an economy of collective practices multiply as patients pick-up on expected conduct. In this way surveillance practices are not simply on or off as someone stands out from the collective. Discipline of one patient or another helps to constitute effects of self-discipline in other patients as members of the collective.

Another way in which an economy of effort is exemplified pertains to the division of work between nurses and patients. Here one strategy employed

by nurses is the 'nurses assignment board' to be used by patients. This practice is a time-saver for nurses in that the responsibility of patients knowing who their nurse is on any given shift is up to the patient, not the nurse. Nurse Leona expresses her irritation with patient Ruth during one community meeting when Ruth asks, "I wonder who my nurse is today?" and Leona responds: "you'll have to go look". This inversion of conventional care practice reveals another way of 'how' patients participate in day-to-day care and in so doing effects an economy of effort for nurses. Patients are expected to go to this board, look-up who their assigned nurse is and then approach that nurse with any particular concerns that they may have. Once patients pick-up and behave as a member of the 'collective', nurses work recedes (although hardly time-consuming in the first place) as patients take over. At this point it is safe to suggest that patients have become disciplined members of the collective/community and in nurses' views, patients display themselves as committed to therapy. Although a collective approach (and its implications) contradicts what nurses claim to provide patients (ie. individualized care), nurses accomplish 'collective' views of patients rather than viewing patients as individuals or persons. Like Durkheim, nurses emphasize 'uniformity' to sustain control.

Translation of interests

In order to accomplish a collective view of patients in practice, however, a translation of interests occurs. Obscured from a view of collective practice is the mode through which 'action in a block' is socially accomplished and recursively legitimates day-to-day practice. Collective practices obscure from view a manufacturing of consent. At Bestcare, members involved in the delivery of patient care espouse that patients receive individualized care. In their interviews and documentation nurses profess the importance of individualized care and claim they spend time with patients on a one-to-one basis. This espousal appears to be contradicted by the evidence that day-to-day practice on the psychiatric ward is accomplished in a collective.

However, the evidence of interaction is more of a nurse to a group of patients. What emerges is that nurses can only 'move' patients around with

aspects of community when patients pick-up on this aspect of practice. So, enrolment of patients in community is vital. Nurses' conduct suggests that they are aware that patients reproduce community and its ethos. Enrolment hinges on a translation of interests of nurse interests into those of patient interests.

I have drawn on the work of Callon (1986), Law (1986) and Latour (1987) to help explain how a functioning network through a translation of interests is enabled in this ward. Law (1986a; 1986b), Callon (1986) and Latour (1986; 1987) discuss the inextricable presence of power in social relations. Law (1986a) identifies "techniques [or methods] of power/knowledge" (p. 14). In addition, I drew from Munro and Kernan's (1993) work (also following Latour) to indicate the importance of "control" and "invisibility" in this process (p. 2). As previously noted, Latour (1987) suggests "inter-esse' indicates, 'interests' are what lie *in between* actors and their goals" (p. 108, emphasis in original). A translation of another's interests into one's own interests (a translation of 'interests') exemplifies how the manufacture of consent is obtained from patients in this ward.

In this ward nurses are able to 'control' a translation of interests and render their own efforts as virtually 'invisible'. Such invisibility is possible as a result of it being the patient who enrols him/herself. Invisibility rests on nurses persuading patients to become enrolled as those who will not perform community stand out as a risk for nurses, in that their control will be made visible. Goffman (1961) suggests that an individual's effort of "bringing the activities of another into one's own line of action" represents one way in which voluntary action of 'the other' can be produced (p. 233). I have shown how nurses facilitate a translation of interests through enrolment. It is important to contrast the process of enrolment with a type of membership such as that one receives in exchange for 'fees' in organizations such as clubs, unions, professional associations (Goffman, 1961) and matriculation at University. The accomplishment of enrolment as social action is the beginning of a patient as a member of the collective. Patient 'therapy' enabling healing is by way of community. Individually their healing is unlikely without voluntarily and socially performing a desire get better through enrolment in community. It is

also not a matter of simply stating that 'I [patient] want to get better', the nurses survey for a commitment to get better in a patient's displays of community (visual and auditory).

Again much of this discussion so far underlines Foucault's emphasis on the 'gaze' of surveillance and Munro's description of 'action in a block'. However, as previously quoted, Munro (1993a) cautions and explains, "Foucault's joke is that 'seeing is saying'" (p. 266). Munro states:

> Something is shown by saying. Hence his tying of the *gaze* to *discourse* (Foucault, 1970; 1973). The expert's power is the ability to pronounce on what can and what cannot be seen (Munro, 1993a, p. 266).

In this view, nurses' accounts to one another reflect *pronouncements* of "what can and what cannot be seen". In relation to patients, language nurses use with patients is disciplining and nurses gaze on the patients includes community performances (which nurses in turn display for one another). This re-emphasizes earlier discussion of the disciplining effects of discourse (community).

Patients who enrol themselves into community instantiate their participation. However, implicated in community membership is the patient's subordination of their interests of their self identity. Patient Eliot displays this well during his admission interview with nurse Nora (discussed on pp. 119-130). While he continues to emphasize that "I was looking for a job", Nora displaces his interests as an individual and repeats the collective day-to-day affairs 'on offer' in the ward. Nora suggests that Eliot does not have to "dive right into this" but, that, after the "first day or so" he will want to get involved. Nora works at 'moving' Eliot around to bring to his attention some of the opportunities he will have access to on the ward. Nora implicitly informs Eliot that he will have to subordinate his interests to the interests of the collective. This marks the expected transformation of Eliot as a 'person' to Eliot as a 'patient' with prospective status of membership in community. He has been pre-figured.

Nurses employ a variety of strategies to persuade a patient to enrol him/herself. During the interview with Eliot, nurse Nora employs a variety of invitations and persuasive moves during her talk with him. Ultimately the gist

of their conversation is that 'there is no alternative' being offered for Eliot. This is underscored by Eliot's wife also in attendance at this admission interview. In this sense, persons external to the ward can also be helpful in nurses efforts to translate their interests into those of identified patients. Manning (1992), following Goffman (1961), draws attention to such collusion of significant others with nurses as "betrayal" (p. 104). On this reading it is ironic that the people who are presumably closest to patients are those effectively supporting, as in the above case, a translation of interests (a patient as a person is organized out).

What emerges is that altering the status of persons through enrolment instantiates that persons, as patients, are inadvertently consenting to such an approach and disregards ways in which nurses have sanctions in place to enlist cooperation from resistive patients. Examining such relations reveals that for patients 'there is no alternative' if they wish to be admitted so as to heal, patients must enrol themselves in community. In this respect then patients can be said to voluntarily consent to community as the only way forward being offered to them. This underscores how the manufacturing of patient consent occurs in this ward.

That a manufacturing of consent is accomplished in practice through community is ironic. The irony emerges in that a device which is typically viewed as attaching people together through often, a utopian understanding of community, here conveys a more astonishing accomplishment. Although community appears to be mundane in day-to-day practice its deployment by nurses has quite extraordinary effects and implications. Utilized as a device, community has the consequence of depriving a patient of the possibility to participate in the construction of the content and process of his/her care other than in particular and pre-determined ways.

Identity and membership

A translation of interests also signals changes in a patient's identity and their membership status on the ward. The constitution of identity occurs through a patient's performance as well as, identity is conditioned by others (ie. nurses). Identity work and the presentation of self as an ongoing feature of

interaction is well presented by Goffman (1959; 1963) and by Berger and Luckmann (1966). I have also drawn from Cohen (1994) to emphasize how a person as patient or a person as nurse performs and constitutes themself as patient or nurse with others. Mere addition (prosthesis) does not give an identity to a person; identity is constituted/performed with others which displays extensions made. A person's identity and membership as socially constructed by self and others, are central to reproducing a smooth functioning network and the ethos of day-to-day care practices (cooperation). On the psychiatric ward, once invited by nurses, patients are expected to behave themselves as though a member of the collective and not as individuals (ie. attendance, community performances). This view is supported by Goffman's (1961) analysis, in that, inmates loose their "identity kits" and are "disinfected of identifications" (pp. 28-29). In this ethnography, which considers an institution rather more open than the 'total institution' considered by Goffman, a part of this involves patients conceiving of themselves as different than before: they are now a patient or a member of community. The effect of enrolment is that patients subordinate themselves (which resonates with Durkheim's view) to the collective *vis-a-vis* a translation of interests. This underscores the process of translation of nurses' interests into patient interests which moves members towards a commitment to community. In this respect, such moves reveal in what ways a person's identity is always running ahead as effected by nurses pre-figured views of persons as patients. In this respect, Strathern(1991) refers to pre-figurements as "anticipated destinations" (p. 80). The way in which nurses pre-figure patients both, enable and constrain possibilities for the constitution of identity and in particular ways (ie. civilian or hospital dress) rather than others: there are preferred or pre-figured readings that one is expected to make. Also, patients who have gone before (ie. those who have resided on the ward for longer periods of time) help other patients in the constitution of themselves as individuals or members. In this particular ward, nurses draw on the ambiguity of an image of community in order to accomplish different figures and extensions of patients as individuals or members. Such an accomplishment underlines the importance of how extensions are made possible through

employing different images/metaphors and associated artefacts: community is a significant device in day-to-day practice.

As previously noted, membership arises as an important notion in the existing literature on the reproduction of day-to-day practice. Cohen, Goffman and Garfinkel, together with Barham and Hayward (1991) 'in' the psychiatric literature, address a view of members and non-members. Membership status is important in discernible and subtle ways in day-to-day practice. For example, in Barham and Hayward's study the issue of membership arises as they focus on the difficult transformation of ex-mental patients into the community following discharge from the hospital. Some of these difficulties Barham and Hayward relate to issues of stigmatization (being identified as a psychiatric patient). Barham and Hayward settle on a distinction between 'difference' or 'membership' which most aptly embraces their research of ex-patients. Ex-mental patients are viewed by members of the community as 'different' and thereby membership to that community is excluded. Barham and Hayward indicate that an "unresolved character of the terms of membership and participation available to people with mental illness in social life" keeps their status as provisional outside hospitals 'in' the community to which they tacitly belong (p. 144). In Barham and Hayward's study ex-patients are different, they are thereby excluded from membership.

In contrast to the literature which gives an emphasis to the either/or of membership my analysis reveals that membership is always partial and this is conveyed in particular ways at particular times. As previously noted, in this study I was concerned to detail how persons produce themselves as patients and nurses. At Bestcare, aspects of identity and membership are signalled by a patient's civilian dress: dress is an artefact. This conveys a patient as a member of Bestcare and of the psychiatric ward in particular. Other patients in Bestcare wear hospital clothes and nurses wear uniforms. Dress signals something about a person's identity. This is consistent with Wolf (1988b) who suggests that by patients wearing of hospital clothes and staff wearing uniforms a statement is made: "differences in dress help the staff distinguish patients from hospital personnel" (pp. 62-63). According to Wolf, dress is read as an issue to assist staff and not patients, where patients are most often in assigned rooms. Such a

position is similar to that expressed by Fernandez (1986), where dress may be read as something to move towards and in this ward, as a mark of 'normality' which persons (members) work towards. On this ward, patient Ginger comments on nurses attire and claims that "(y)ou are still your profession, no matter what you wear" (p. 94). I take this to suggest what Goffman (1963) points out, in that a person's attire is often linked to the "maintenance of expressed distance" (p. 222). However, in Ginger's view, nurses civilian attire may not 'express a distance' but neither does their dress counteract other aspects of how nurses constitute themselves with patients. And similar to Goffman's (1953) study of Dixon where he and members of Dixon suggest that there are two groups of members ("gentry" and the "locals") and that they know who they are; in the ward nurses and patients know who's who (p. 16). Members of the psychiatric ward (patients and nurses) 'stand out' by their civilian dress which helps to create the appearance of person-as-patient, person-as-member and person-as-nurse. Although dress is an immediate visible cue of a member's status, other aspects of identity are recursively produced during interaction and are stronger cues for members than dress. "Persons are separated from one another by their relationships" (Strathern, 1992b, p. 9): nurse from patient.

Another significant finding is that membership status is provisional (Munro 1993b). By provisional, Munro suggests that inclusion to membership is never settled. How individuals act displays aspects of their identity and in turn their membership status. For example, a patient not queuing up for medication may suggest that he/she had either not been instructed, or has not yet 'learned' (become disciplined) that such behaviour is expected of patients. Cooperating with the provision of medication, conveys that a person has been transformed into a patient (person-as-patient), but not necessarily a member of community (person-as-member). Similarly, patient activities such as showing up for meal times, making their own beds and so on, exemplify aspects of a patient identity but not necessarily a member of community.

Patient behaviour displays them as members or non-members. Cohen (1985) explicates how individuals acting out of order are distanced and sometimes labelled as deviant. As already noted he suggests that an individual's action is a display of his/her 'membership status'. Nurses are not

opposed to directing patients regarding aspects of 'do patient' and in so doing obtain patient cooperation (Rosenthal, et. al., 1980). A patient's membership status also emerges as nurses employ the 'threat of sanctions'. Nurses frequently express such sanctions in terms of "encouraging" a patient to be cooperative. Nurses employ sanctions to help to 'hold' particular organizational arrangements in place and constitute a patient's identity. The phenomena of 'being noticed' signposts an instance of the association of action and asymmetries of power relations in day-to-day activities. Gadamer's (1989) treatment of individuals implies that everyone can have 'membership'. However, his view of interaction seems to be based on views of ideal interaction and overlooks the effect of power relations. In this sense, I suggest that the virtual absence of his conceptualizing power relations explains this important difference. In Gadamer's view, people 'work at' and are enabled by others who are also working at 'belonging' through "communal" (p. 379) activities. Through considering distinctions of membership (the possibility that membership is partial) I have shown that not everyone is working towards such an aim, nor is everyone given the opportunity to work towards such an accomplishment inside the ward. Emerging out of the ethnographic material is the finding that nurses manipulate patient belonging. Identity of a patient is produced and reproduced in day-to-day relations with others. Others, such as nurses, pre-figure and help to constitute a person's identity (patient) at any particular moment in time. Such constructions reflect how nurses manipulate membership in ways which make membership status 'moveable'.

Included and excluded membership

Importantly, although there is an elasticity, to who is 'included' and 'excluded'; nurses are the gatekeepers for community membership. There is a network of conditions which appear to effect whether nurses 'include' or 'exclude' patients. What emerges is that there are partial connections, which are not fixed, but are employed by nurses at particular times to legitimate their accounts of patients (Strathern, 1991). This adds to the ambiguity of aspects of community and provides further leverage concerning patients granted membership. By paying attention to similarities and differences, as Cohen

recommends I have shown how subtle 'moves' are displayed in day-to-day relations between nurses and patients. Patients can be said to default themselves, but, nurses assign a patient's status on the basis of 'mental and physical characteristics'. All persons admitted to the ward receive a formal patient status but this should not to be confused with community membership status which nurses work out between themselves. There are distinctions between patients and the way in which nurses relate to them on the ward (person-as-patient or person-as-member-of-community).

Those patients who are deemed by nurses to be those who will cooperate with the collective are included. Those who are not included are patients who are viewed by nurses to include behaviours such as: "weepy"; "bizarre"; "physical limitations"; "too chronic"; and "she's only monosyllabic". Nurses refer to these behaviours to legitimate whether patients are granted membership status (ie. "guarded", "withdrawn", "not talking yet", "being quiet", "manic", "depressed"). In short, those patients who are viewed by nurses to be 'disruptive' are excluded. Patient Bertha stands as an explicit case for nurse Jennifer who claims, "it's easier on us [nurses]" to maintain Bertha as having only a 'patient status'. However, nurses employ language such as "he is too psychotic still" and "she's too weepy yet" to signal exclusion as a patient's *current* status of membership for 'doing community'.

As previously noted, what emerges is that patients' actions are those which nurses use to recommend membership or not. In this sense, patients can be said to rule themselves out. Patient Gwen indicated that she understands that she is not invited to attend activities as a result of depending on a walking cane to get around. I have suggested that it is significant that patients too are able to articulate (work out for themselves) aspects of this selection process. As presented in Chapter 4, patient Ginger claims that if "you [patient's] are willing to cooperate" that nurses will "cooperate with you" and that there are patients who are willing to cooperate (p. 113). Again this example reflects that patients become disciplined and so legitimate nurse practices.

Patients who are excluded from membership to community are provided highly routinized and minimal care efforts (ie. Ret and Bertha). Moreover, patients such as Bertha and Ret exemplify patients who are socially excluded

from community by nurses. In this sense, nurses manipulate belonging and 'detach' some patients by not permitting patients access. Nurses' discussions with one another (ie. kardex) and accounts with me reveal that nurses have a preference for patients included as a member of community who can be acted on as 'action in a block' in that, "it's easier on us [nurses]" (p. 115). Membership status interpenetrates and legitimates the receipt of 'activities of care' from nurses. Goffman (1961) suggests that inside a total institution patients are all treated the same and that they work out permit-able identities with staff. However, I have suggested that aspects of membership status are distinguishable among patients. Such variations are effected not only by nurses' views of patients but also through patient conduct. Patients act on and through each other.

Finally in relation to identity work, Fernandez (1986, pp. 188 - 213) suggests that, people in an ongoing manner competently manage the self even in abruptly changing circumstances in what he refers to as a "return to the whole" in a "state of relatedness" (p. 191). This appears to be a return to familiarity. In what I refer to as a second work space (patient-patient interaction) for community, an important contrast arises in relation to Lynam's (1990) study. She suggests that doctors and nurses focus in day-to-day practice on what she refers to as 'patient identity' versus 'person prior to the diagnosis of cancer'. Such focus for patients diagnosed with cancer, she claims results in patients, having a non-integrated view of the self. In turn this fragmentation leaves patients experiencing a fragmentation of the self in day-to-day care. My analysis reveals that patients return fragments to a whole in Fernandez's (1986) terms. Patients do the work to make sense of community for themselves and for their 'selves' but they do this is ways which largely, do not interfere with day-to-day practice of nurses. Indeed I have tried both to suggest that patient resilience and self-discipline emerge as products and effects from a complex network of surveillance, enrolment and sanctions.

Chapter 9
Reflecting on community

My concern in this thesis has been to detail certain organizing practices and their effects. I was interested in eliciting from my study of a hospital ward some general features of organizing, rather than to examine the specifics of a psychiatric ward as being prototypical of other psychiatric wards. Although I have closely examined a specific ward, there is no reason that readers should assume that practices in other work areas should be substantially different. As detailed analysis of a wider view of organizational practices (including administrative and physician as well as formal and informal day-to-day practices) indicates, I think my analysis of organizational practices in one ward at Bestcare reflect the tendencies throughout the organization. Organizational practices are reflected across a spectrum of fields and disciplines which includes distinguishable areas of hospitals.

This is not to suggest that my analysis is indifferent to specific practices. Far from it. In this ethnography I have made every effort to enter the site and describe a psychiatric ward within the terms that it sees itself, or in Geertz's terms, "at what the practitioners of it do" (1973, p. 5). I have not imposed "distal concepts" but rather, chosen to see the ward in its making, employing a view of proximal organizings (Cooper and Law, 1994, p. 2). In this way, this exploratory study contrasts with, say an evaluative study as I make no attempt to evaluate the work nurses do in terms of prescriptions for practice. Avoiding the ground of prescription corresponds with an ethnographic approach (Latour, 1987; Cooper and Law, 1994; Strathern, 1991; Law, 1994).

I have attempted to explicate organizing practices which concern work which nurses conduct with patients in a hospital ward. Following Rosenthal, et. al., (1980) the day-to-day practice of nurses:

> can appropriately be analysed as work for work it is. Seen as work the behaviour [conduct] of nurses (...) is readily understandable as a normal way of working. People normally or usually develop a commitment to their work, and hold ideals about what is the best or appropriate way to do that work (p. 139).

In contrast to Rosenthal, et. al., I treat work as a process of proximal organizings. Within the ethnographic approach definitions of work are deferred, and evolve from understandings of the nature of work in the site, rather than viewing work as a fixed entity in ways suggested by the analysis of Rosenthal, et. al. While clearly wards such as psychiatry reflect the division of labour as discussed, practices of detachment emerge and as such reflect wider organizational arrangements at Bestcare that should not be viewed as peculiar to the psychiatric ward investigated in this study. Adopting Cooper's (1989) phrase there is a labour of division. I suggest that there is a labour of division which may produce a view that practices on the psychiatric ward are inherently different. Bestcare members work to make such differences apparent. However, there is no reason to assume that a labour of division particular to a psychiatric ward will be so substantially different from practices of detachment in other organizational practices. As the Organizational chart of Bestcare suggests, units of organization represent a division of labour. Further, as Munro (1994a) states: "organizing is not so much to bring things together as it is to keep things apart" (p. 11). Members of Bestcare work to produce and reproduce difference between themselves and others in daily interaction: "preventing that which is held apart from becoming the same" (Munro, 1994a, p. 11). Such a view also cross-links with Strathern (1991) who suggests that "relations are created in the separation of persons from one another" (p. 111).

Drawing on these sensitivities, I have explored the organizing of patient participation by examining the work which nurses do and the work which patients do. Treating patient participation as something which is organized through work spaces extends existing views of patient participation. I have shown how limiting the study of patient participation to patient-nurse interaction, as many studies do, fails to take account of the wider constitution of patient participation or as an organizational accomplishment. The conditions of possibilities for patient participation are implicated by organizational

arrangements of members of Bestcare (including administrators, doctors and nurses) and cannot be reduced to particular types of interaction.

I have also shown how patient participation invokes aspects of community. However, it is important to use some discretion and not assume that all participation is community and vice versa. This is remarkable especially given Bloor and McIntosh's (1990) study (discussed on p. 71). Among other things, community within the ward I studied is a technology of control which is used to regulate particular interests in particular ways at particular times. Nurses rely on patients picking-up the importance of community in order that day-to-day practice occurs smoothly. The examination of the psychiatric ward illustrates ways in which persons *are* involved in the constitution of day-to-day practice. At times patient participation involves an inversion of conventional care practices such as patients finding out who their nurse is rather than nurses informing patients that he/she is a patient's nurse. Hence, the scope and potential for patient participation is grounded in the routine contacts between recipients and providers in a hospital. In this ward, through practices of detachment, nurses, doctors and administrators enable patients to participate in their day-to-day care. Simultaneously these members of Bestcare constrain participation during a largely *pre-figured* space of hospital practice as their resource (ie. reduction practices and exclusion practices). Together, these help to explain how patient participation occurs in particular ways and not in others: there are partial distinctions that are fluid yet partial connections which are also fluid. Patient participation is not fixed.

In the ward, *pre-figured* spaces of work such as kardex supply terms that can be deployed by persons to mark out and label the identity of others in a continuous process of naming. Such "identity tags" help to constitute a person's identity by others (Cohen, 1990, p. 13). For example, nurses routinely conduct work activities into which different patients, in particular ways rather than others, arrive and enter this naming process. To make the transition from being a person to becoming a patient is both to enter a *pre-figured* space and, however transiently, to resonate, this pre-figuring.

What I have gone on to show is that membership does not stop at the hospital door. Being a patient marks only the beginning of one's membership

work in community to which I now turn. Language of community is disciplining for nurses and for patients. Patients are moved about by talk of community, as a discourse, in particular ways at particular times. Community is a key term to 'move and displace' patients. Although community is a sufficiently common term, on the ward differences between *shared expressions* and *shared meanings* are overlooked by nurses. The very motility of the term is central to its regular deployment in this particular hospital ward. Here, polysemicity of the term 'community' enables extensions in day-to-day practice for nurses and patients. Further, such motility underscores the importance of a researcher not defining community (in some other *pre-figured* space) in advance of their study. Also, in this respect, moving through different studies in the literature, and aspects of how community is conceptualized, reveals different forms of extensions. For example, as a geographical marker, community includes a particular mode of ordering of that which is studied. In contrast, in this thesis, I have shown how different aspects of community emerge from a view which sustains a focus on social accomplishments of community. In order to present, yet not privilege a particular view of community, I selected to employ literature to help open up any particular view of community. Strathern (1992) claims:

> The very desire to put facts 'into their context' is a merographic move. The context, by virtue of not being equivalent with the thing put into it, will 'illuminate' the thing from a particular angle (display one of its parts) (p. 73).

Theoretical material presented in Chapters 1-2 was intended to enable readers to problematize the study of day-to-day practice in order to open up one's view while at the same time, not privileging selected aspects of empirical material in advance of detailing important processes of day-to-day practice. The irony, yet, relationship pertaining to how structures (in this study community) are employed in day-to-day practice, as well as, their effects reveals important differences between my study and previous studies concerned with examining community. In particular, community as deployed by nurses detaches patients from nurses. Once patients and nurses are detached, the day-to-day business of 'doing patient' and 'doing nurse' ensues, a division of labour is recursively reinforced by their subsequent contacts. Patient contacts with nurses reiterate an

'us' and 'them' division that emphasizes who members of community are and who the large majority of the work rests upon. The day-to-day accomplishment of a division between nurses and patients is the first instantiation, on the ward of the 'divide and rule principle' (Barnes, 1988).

A second division of 'them' and 'us' operates to split the patients between those who are included in the group permitted to community and those who are excluded. Nurses continuously manipulate membership to community. Further patient membership is implicated by nurses constituting their identity with patients which in turn affects the constitution of patient identity for themselves. Nurses work out amongst themselves whether or not a particular patient is to be granted membership, but their would-be-membership is also affected by a patient's conduct (cooperation). If I am an 'us' and you are a 'them', our positions relative to one another become known and recursively constituted in day-to-day practice. Likewise, if nurses designate that a patient will be permitted membership status as a member-of-community, nurses constitute a patient as a member-of-community in their day-to-day interaction with patients and other nurses. The process here seems to correspond with Barnes' (1988) view of 'bootstrapping' where names in use require a "*priming*" (p. 529). As with a feedback loop, he suggests that once a name is in place, subsequent inductions hinge on previously patterned inductions. In the ward, subsequent nurse-patient interaction bootstraps a patient's identity from that which is *primed* or put into play during kardex (nurse-nurse interaction). For instance, nurses settle on a view of patients (ie. Stella, Bertha, Duncan, Oonaugh), and then put this view into play during their face-to-face contacts with patients. This practice also reflects Cohen's (1990) view that such naming reflects how members "supply selves to others [ie. patients] and that this process is based on assumptions that "there is no dissonance between *our* construction of their selves, and *their* sense of their selves" (p. 17).

On the ward divisions of work suggest a network of conditions which affect nurse interaction with particular patients. Subtle distinctions between 'us' and 'them' are also exemplified in nurses' face-to-face interaction with patients such as 'gift-giving', where patients provide nurses gifts and patients in turn receive 'wishes'. As already noted, Ferguson's (1992) reading of wishes is

that they are "insincere and childish" (p. 31). It is noteworthy that gift-exchange is viewed to be an important aspect of practices constituting community (Strathern, 1991; Cheal, 1988; Barley, 1986; Fernandez, 1986; Mauss, 1990). Strathern states that gift-exchange reveals "the anticipated outcome of the transactions which produce it" (1991, p. 118) and in this sense reveals a making present. Gift-giving and community are conventional displays or expressions of the constitution of identity of self and other. In the ward, this particular exercise helps to reinstantiate 'us' and 'them' and they all know who is who. The labour of division reinstantiates the division of labour: patients are community members and nurses are therapeutic instructors.

Arising out of the above mentioned 'us' and 'them' distinctions are three distinguishable community work spaces: nurse-patient interaction; patient-patient interaction; and nurse-nurse interaction. The first work space for community which I elucidate is constituted by nurse-patient interaction. Although this represents a minor portion of day-to-day practice (refer to Table 1, p. 51), as already noted, extant literature on patient participation typically examines only this work space. To concentrate on this portion of daily practice, therefore, displaces other important features of day-to-day organizational arrangements. This first work space is produced in the day-to-day together with two other work spaces on the ward: I have attempted to draw attention to the inter-relations among all these work spaces. For example, during nurse-patient interaction, nurses mobilize the key term community to organize their day-to-day work and, as has been shown, the effects of this ripple through to patient 'solo' work. Each person at Bestcare gets to know who they are in relation to others. Relations with others affect and are affected by the constitution of a person's identity. Identity is, then, partially constituted by what one person's performances display but importantly, also, by the identity which the other produces (Cohen, 1994). In the *pre-figured* spaces of a hospital, identity is always running ahead. Through a complex process of naming identities are always being pre-established. This practice underlines that naming is not only a theoretical move of researchers as explicated by Cohen (1990), but that this process, is part of day-to-day interaction. Further, although not elaborated on in this thesis, such work is not peculiar to nurses' work with patients but also is

integral to identity work of administrators and doctors among themselves and with others. Only particular variations of persons identities are accommodated: others are excluded. Importantly, a nurse-patient work space is used by nurses to train patients to 'do community' which they link to that which a patient will 'need' when they return to the wider community outside hospital. Here, there is a sense in which a patient, constituted as a member of community, leaves hospital with 'more' than he/she came with. I have suggested a number of ways in which this reflects Strathern's (1991) discussions of prosthetic extensions.

The second work space for community is during periods of time when patients are left alone (ie. nurses are not present). Researchers appear to have overlooked how important this space is to the constitution of day-to-day practice (Wright, 1994). This neglect suggests a tendency to assume that 'therapy', 'care' or 'treatment' in hospitals occur only in face-to-face contact with providers (ie. nurses, doctors and so on). Certainly, in this work space, nurses leave open the ways in which community can be interpreted. But their *physical* absence does not entail the absence of therapy. During these periods of time, patients engage with each other in ways which appear to reflect everyday understandings of community, possibly with therapeutic effect. Nevertheless, I do not wish to suggest that, left alone, patients cure themselves. My findings reveal that patient-patient interaction also resonates with discourse effects from nurse-patient interaction (ie. community performances of patients; discussion among Ginger, Oliver and Patsy; and interaction between patient Ginger and her husband Baxter). Although mine is an exploratory study, not an evaluative one, future studies might do well to bear in mind the complexities of discourse effects. Just as the patient work space cannot be hermetically sealed from the effects of patients mixing with other patients, so the discourse of nurses is bound to penetrate patient work spaces.

This particular finding conflicts with, for example, Giddens' (1984) view of 'agency' where agency is instantiated only by a person to whom the agency pertains. My findings suggest that agency is a more motile and distributed notion than many sociologists may like to imagine. Nurses and patients can transport (export and import) discourse from one work space to others. Just as

when a stone is dropped in water and the ripples remain visible long after the stone disappears, so, discourse has its effects in *other spaces than that in which certain forms of words are uttered* For example, community as a structure, although initially employed as an organizing structure by nurses, may affect patients' everyday understandings of community in their daily performances on the ward. Patients re-materialize the agency of nurses, drawing from discourse employed during nurse-patient interaction, just as the agency of a patient is re-materialized in a patient's physical absence. Structures have effects which extend beyond their initial and intended instantiations.

A third work space in which aspects of community emerge is that of nurse-nurse interaction. Two aspects of the accomplishment of care emerge from this work space. First, nurses construct accounts of patients which in turn affect potential participation of patients; that is, they *prime* the ways in which patients will be granted membership. Second, through nurse performances of patients, patients participate only in their absence. I have shown that nurses are skilled at producing patients, even when patients are (physicially) absent. If, as Rosengren and DeVault (1963) claim about obstetric patients, a patient's presence "need(s) to be defined" by doctors and nurses in order that she [patient] will know what to do, then, in reverse, that the same holds for the patient's absence is not surprising (p. 289). Nurses produce patient participation, identity and membership to community while they are removed from face-to-face contacts with patients. This work involves a literal *performance* by nurses of patients as 'figures'. It is through the production of these 'figures' that nurses pre-establish who is to be allowed to continue to 'do community' and who is to be kept outside, as in the case of those patients who have 'refused' community. For this work, it is important to note that nurses draw from their experience in the first work space as well as from their previous knowledge about patients and about psychiatric discourse (ie. Bertha). Effectively, while patients are 'doing community' in the ward, nurses detach themselves from patients and create patients. In addition, nurses constitute themselves as members of Bestcare and distinctions among them are apparent in their displays of patients.

In detailing day-to-day practice, and explicating aspects of such practice drawing from Strathern (1991; 1992; 1994), what emerges is the appearance of

figures. I have explicated the movement between two figures of persons, a dialectic: persons-as-individual and persons-as-members-of-community. These figures diminish and stand out as translations and transformations of persons aspatients are constituted in day-to-day practice. I have shown how images of community are asserted, first by nurses, performed by patients and thereby organize considerable activity for persons making up day-to-day practices on the hospital ward investigated. This dialectic movement also poses an intriguing association with taken-for-granted aspects of therapeutics. For example, a person as patient coming out of themselves as individual implies a return to the healed self which is accomplished through becoming a member of a community. Moving from one figure (individual) to another (member) accompanies what appears to be a therapeutic effect for persons as patients. In other words, the way to a healed self is through getting out of the individual in an organization and moving to a member of a community. This appears to be a movement towards 'healing' as portrayed in day-to-day practices on one hospital ward. Extending this line of discussion and contrasting notions of what is viewed to be therapeutic/therapy for the self as individual suggests a different reading of conventional healing processes such as psychoanalysis. Psychoanalysis assumes that when a person is assisted to come out of the self a healed self results. In this case, the voice of an expert facilitates talking and insight which works in a direction from the inside of the individual to outside (expressed talk). This view rests on the assumption that expert authority is underpinned by superior judgment and insight. In contrast, the current thesis suggests that through 'doing community', movement of a person as patient to member of community is that which is therapeutic and a healed self can be said to be accomplished.

The use of community as a device to accomplish healing is then politically sustained as one form of expertise against another. In this view, community as a device is much cheaper, for example, than psychoanalysis, and community is returned to as a good in two senses of work. For example, community is frequently perceived as a good which occurs in different forms. Community is made a commodity, a good, in the sense that nurses can produce or help patients accomplish some sense of therapeutic, and it is made desirable

as against notions of individuality. Here, an economic presence and tie between commodity of good(s) also integrates a concern for efficiency and effectiveness. The second sense of community as good resonates with a sense of a healed self: community is good. In this study there appear to be particular understandings of community in use. When persons as patients express aspects of individuality then, nurses see it as their job to turn notions of community into membership: through membership patients can accomplish/achieve a sense of self. It is also important to note that I am not implying that there is any stability or healing, but nurses do. As previously noted, nurses make such claims as experts. I suggest, understandings of community in use (in day-to-day practice) implicate those aspects of community which patients (and nurses) are familiar with and thereby have currency for them. Currency is practical in the ways in which it is useful and sufficiently well known to patients and nurses in that, it works: community is profitable.

So 'how, then should we think of community?' All too typically, ideas of 'organizations' and 'community' create something of an aporia when one is considered with the other. Writers referring to organizational culture (Deal and Kennedy, 1982; Smircich, 1983a; Smircich, 1983b; see also Morgan, 1986 for an extensive review) suggest that community is distinct from, or residual to, organization. For some community is treated as something which is separable from organization or as a different order of organization. Another contrast arises when writers suggest that organizations are a more primary order, while community is residual (ie. Ouchi and Maguire, 1975; Ouchi, 1977; Ouchi, 1979; Ouchi, 1980; Ouchi, 1981). Such views arise implicitly in talk of the informal and formal, proximal and distal and in terms of clans and kinship. Hillery (1968) makes a distinction between organizations and community and suggests that organizations are interested to attain goals while communities do not have this emphasis (also noted by Bell and Newby, 1971). From another perspective, the entities of community and organizations are described as being located outside of each other. For example, Cohen's (1985) view suggests that community should be viewed as a larger entity, as something which can stand outside and contains organizations (organizations are within community). The findings in this ethnography suggest a different approach.

The question of how to think community can be responded to by noting the importance of community as an organizing structure in the accomplishment of day-to-day practice in hospital. Day-to-day practice requires a labour of division which, in turn, instantiates divisions of labour. At Bestcare practices of detachment create separable work spaces which are mutually beneficial for nurses and patients. By separating such work spaces, nurses promote richer community performances by patients than perhaps could be achieved by direct nurse-patient interaction. For patients, community provides a distinguishable mode through which they can accomplish healing, through other patients and by making absent nurses present.

Another important difference raised in the discussions of this thesis informs further considerations for 'how we think community'. This links directly to the distinctions between formal and informal organization. Typically, community is seen as shaped through formal means, a view that suggests that formal and informal organizings are independent notions. The work reported here questions the validity of the distinction between formal and informal. Formal and informal practices are inextricably inter-dependent. Given the significance of membership work, for example, the formal is as much people doing membership work as it is schedules, documentations and so on. In the current study, methodological considerations are not divorced or split into a world of formal and informal practices. Such a view is supported by authors such as Law (1994), Latour (1987; 1991) and Munro (1993a; in press). To take a view that formal and informal distinctions should be made is to see some spaces as more social than others.

Eliminating the distinction between formal and informal enables a shift in emphasis (thinking about organization of community). This shift in emphasis helps explicate how organization of community is not accomplished by dividing up spaces of day-to-day work. Taken one step further, to segregate day-to-day practice into distinctions such as formal and informal aspects of community relegates community to something *other* than organization.

Strathern's work (1991; 1993; 1994a) offers a way through socially constructed distinctions of formal/informal and develops notions of how people cut figures. Strathern suggests that the day-to-day is not like moving

into formal spaces at some times while at other times moving into informal spaces. Instead, persons make extensions and movement between figures with artefacts which rely on attachments/ detachments and connections/ disconnections. Movement across figures helps me sustain the formal organization as well as explicate how persons constitute themselves as a member of community: "any singular figure is already a composite" (Strathern, 1994a, p. 6). As previously noted, I have made these moves in the narrative work and have attempted to help the reader to be able to make these same moves.

The relative ease of the moves from one figure to another suggests that only a few artefacts need to be shifted in day-to-day practice. This emphasizes first, how persons are capable and competent to pick-up on notions of community. Second, performing community relies on their past experiences. I suggest such competent performances indicate that artefacts are common to work spaces of patients (as both individual and member of community) and nurses. Artefacts help persons shift from one figure to another (thus interlinking distinctions between human and non-human world or formal and informal). According to Strathern, sociality appears to "move like a figure against a background of persons and relationships" (p. 1991, p. 114). The relatively few artefacts employed to make these moves suggest that persons do not live apart in separate spaces: there is a commonality which makes extensions possible.

Approached in more traditional ways, community and organization are presented as entities which can be held apart. In the nursing and health care literature hospitals and health care practice (ie. community health nursing/services; notions of community care; 'therapeutic community') are described as being separable from the wider community within which they are situated and which ostensibly they service. Traditionally community is viewed as divorced from organizations such as hospitals except in the (bizarre) notion of a hospital or ward having its 'own' community. To view organizations and community as distinctly different orders leaves notions like community open to be used as a device which helps to regulate particular 'interests'. As already quoted, Cooper and Law (1994) suggest that "distinctions in the human world

are not naturally given; again, they are products or effects of ordering or organising" (p. 4). My work suggests that organization and community cannot be accomplished in the absence of one another. Community and organization are not two separate or self contained entities. Instead community and organization are aspects of more encompassing social practices. The becoming of each is conditioned by and relies on the other.

Appendices

Appendix 1

Negotiation of access and selection of hospitals

I approached six hospitals in Western Canada to negotiate access for the conduct of this study. In each of three hospitals access was granted to two wards which included ethical reviews by Research/Development and Hospital committees. Two of these hospitals were selected to provide a cross-section of specialty areas such as medicine, obstetrics, surgery and psychiatry. Ethnographic material was collected from two wards in each of these hospitals. The negotiation of access and the collection of research material, in two wards in two different hospitals was conducted in order to avoid the limitations which can occur from the use of a single setting (Yin, 1989).

This thesis examines practice in one hospital and one ward in order to adequately analyze and present the research material. The ward is a medium-sized psychiatric ward. This ward is described as a medium-sized ward which ranges between 30-40 patients. The precise bed capacity is not being disclosed to protect anonymity. Research material from other hospital wards will be published in other forms. Research material includes observation, interview and documentary sources. The research collection period on this ward was eight weeks and three months within the hospital. The hospital is a 500 bed, acute care facility offering an array of specialty medical services to a large geographical radius in Western Canada. For reasons of confidentiality the name of this facility will not be disclosed but will be referred to as Bestcare. Bestcare includes a full range of medical specialty wards where the potential for patient participation occurs on a daily basis between providers and recipients of health care services (see Organizational Chart, p. 288).

Five distinguishable groups - patients, nurses, administrators, doctors and a smaller group of psychiatrists and psycho-geriatricians - are included. While acknowledging the important differences among these groups this research project, for the purpose of brevity, concentrates on these general areas of expertise. However, when it is important to distinguish expertise of a particular group I point this out in my discussion.

Negotiation of access to Bestcare was a straightforward process. A research proposal was developed and submitted to Senior Management. Three telephone calls occurred between myself and a member of Senior Management. The first telephone call was initiated by me when I requested permission to send on a research proposal to be reviewed. The second telephone call was initiated by a Senior member of Administration who discussed how he/she had

interpreted what I was requesting from Bestcare. My proposal was discussed among members of Senior Management which was then forwarded to the Hospital Board of Trustees for final approval.

The third telephone call followed written permission from the Hospital Board of Trustees indicating that I had been granted access to Bestcare. At this time a member from Senior Management sought details regarding when I wished to commence the project, as well as, which hospital wards I preferred to use for the collection of research material. The negotiation of access spanned a three week period. Access to two wards was agreed upon (aligning with my request) in this hospital.

Prior to the commencement of my data collection period at Bestcare, all members working within the hospital had access to a hospital bulletin which announced my research project. The announcement was repeated each month during my time within the hospital. Also, records from a number of departmental meetings across the organizational hierarchy included notice that I would be on site collecting research material. This was initiated by members of Senior Management.

Also prior to the commencement of collection of research materials I had a meeting with the nurses on duty (in the ward where I collected research material) as agreed to by the Head Nurse. During this time I discussed my general plans for observation, interviews and a review of documentary material and fielded their questions. I requested that if they had concerns or problems with the way in which I was conducting the collection of research material that they inform me of such. No concerns were addressed with me nor (as I was told) by others in the hospital. This preliminary contact was recorded in the ward's informal communication book for nurses who were not on duty at the time of this meeting.

The hospital and members of the hospital have been given fictitious names for this thesis in order to protect their anonymity. Each member from Bestcare has been given a name as I believe the identification of a name rather than a 'code or number' enhances a view of subjects as persons. As agreed at the proposal stage of this research project the hospital is described as an 'active treatment hospital in Western Canada' with identification of the ward by functional area only (ie. psychiatry).

I now turn to identify how three sources were employed as methods in the collection of research material.

Methods employed

Three methods were employed to obtain representations of members' everyday understandings/knowledge of practice at Bestcare. These included observation, interviews and a review of documentary sources. The use of three sources of research material is described by Campbell and Fiske (1959) as triangulation. The aim of using triangulated sources is often stated as one of optimizing the validity of the research finding by not relying on one single source of research material. Webb et. al., (1966) and Denzin, (1970) suggest that triangulation of research material enhances robust interpretative accounts. Rohner (1977) claims that the weakness of relying on small sample studies is

compensated by the strength of using material drawn from triangulated research sources by enabling cross-checking. While such statements are in danger of exaggerating the benefits, cross-checking sources has enabled me to question initial interpretations. Of itself, however, it cannot itself ensure sound interpretation. Certainly the absence of any cross-checking of sources of research material (observational, interviews and written documents) would limit a reader's confidence in the findings (Janesick, 1994, pp. 209 - 219).

Observation material

The discussion in this thesis has consistently pointed to the centrality of observational material. Such material is a representation of empirical reality delineating members action with others in one hospital. The material in this thesis is taken from observational notes, written during periods of observation, which have been cross-checked with tape-recorded accounts accumulated simultaneously during these periods of observation. Written consent was obtained from persons involved directly in the observation periods.

On the psychiatric ward, I collected observational material for 4 to 6 hours per day. All observation material was collected between the hours of 0500 and 2400 hours across a range of week-days. The observation material provided a cross-section of interaction occurring amongst patients, nurses, doctors, as well as, other health care providers from a variety of locations in the ward. For example, these included: change over reports; kardex; patient group activities (morning and afternoon); unscheduled ward time; admission interviews/assessments; family interviews/assessments; couples interviews/assessments; one-to-ones between patient's and nurse's; interaction among and between patients, nurses and doctors; and liaison meetings between nursing staff and community agencies affiliated with psychiatric care outside the hospital.

Initially I was identified and advertised, by members of Top and Senior Management, as a researcher within the hospital. This provided me with a special status exempting me from conducting work in the way in which other members within the hospital did.[1] Czarniawska-Joerges (1992) refers to this as 'observant participation'. Gold (1958) identifies this as 'observer-as-participant'. Putnam, et. al., (1993) also refer to 'participant observation' which describes a researcher's presence during the day-to-day conduct of practice. These varying terms convey what Munro (1994) identifies as the 'ethnographic presence'. Such presence grounds all subsequent research achievements. In this study 'participant observation' conveys that I was a participant in those activities which members of this site practiced. I asked to be treated like 'I am invisible or part of the furniture' during my observational periods on the ward. As a result of my presence I likely had some effect on day-to-day interaction. However, I concerned myself with the activity of writing during these periods.

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[1] There was one exception to this being accepted by all organizational members. On one occasion I was near the nursing station and a telephone began to ring. As usual I did not respond to the ringing telephone in which case another member said as she walked by "nice ring Maxine" and answered the phone cordially.

In addition to observational material from the ward I attended a broad range of meetings occurring within the hospital. During the first week of my presence at Bestcare members of Senior Management informed me of an array of meetings and provided me with schedules. Thereafter I was included on the mailing list of meetings, agendas and minutes of these meetings. These included regularly occurring committee meetings as well as committees which had been struck to tend to specific hospital projects over a shorter term basis. In other cases, I attended meetings which were held between two or three members of the hospital for purposes of reporting and exchanging information up-and-down and across the formal hierarchy. For example, Nursing Officers and Heads of Divisions had monthly meetings during which they reported to their respective Vice-Presidents. Likewise, Head Nurses reported to their Nursing Officers. In all such meetings I was allowed to tape-record such contacts as I wished. I attended a cross-section of organizational practices (formal and informal) related to hospital affairs. The observational material provides a broad range of interaction and activities as they occurred at Bestcare. In all such encounters I attempted to be informal and was met with friendly assistance by members of Bestcare.

With the regularity of my presence on the ward I became known as "the researcher with the red folder and tape recorder". Comments such as "she likes to be ignored", "she writes a lot", "she's my shadow" and "she's just part of the furniture around here" were expressed by nurses and patients with ease. In these ways, my presence was referred to in an 'absent' way. My presence was accepted and did not appear to interfere with day-to-day practice (verified on several occasions by members within the hospital). Such receptivity also supports and relates to my own 'understandings' about day-to-day practice in hospitals. In this sense, as a researcher informed about the setting where research material was collected I was in a position to be aware of 'typical' activities and whether local alterations in practice were made for my purposes. This view would be distinct from someone unfamiliar with day-to-day practice in a hospital.

I kept an ongoing log recording periods of observation and audio-tapes to assist me, at a glance to refer to locations and times of where observational material had been collected. Each day I transferred my hand written notes (constructed at the time of observation) cross-checking these with tape-recordings and putting them into my personal computer. I was able to complete the majority of transcribing related work during the two month period. However, the remainder of this work followed the collection of research material at Bestcare. This time-consuming process occurred around other activities such as conducting, observation periods and scheduled interviews to which the discussion now turn.

Interview material

The second source of research material collected was interview material. Thus in tandem with observational material, interviews provided interviewee's accounts of their day-to-day activities. Interviews were conducted with a range of patients, nurses, doctors and administrators using a semi-structured format. Two interviews were conducted with each interviewee and they ranged between 1-3 hours. All interviews were tape-recorded and transcribed by me. Interview accounts from the psychiatric ward involved 6

patients and 12 nurses. Five doctors who admitted patients to the ward were interviewed as well as 7 administrators from Bestcare. Several other interviews were conducted in this hospital and included: dieticians; pharmacists, respiratory therapists, educational coordinators, and social workers. Patients, nurses and doctors associated with the second ward where research material was collected were also interviewed although this material has not be used in the analysis.

Interviewees were selected on the basis of convenience and interviews were conducted with patients, nurses, doctors and administrators across the hierarchical levels of Bestcare in order to gain a cross-section from each of these groups. My aim was to guard against obtaining a 'one-sided' view from any of these distinguishable groups. Hence, I obtained a range of interview accounts which provided multiple perspectives of day-to-day practices of organizing the provision of and receipt of care and treatment.

First Interview

A semi-structured format was used. The interviewees largely directed our interaction to discern activities and issues of concern to them, while I had a backdrop of questions and statements to help change the direction of talk as seemed suitable at the time. This approach has also been described with success by Munro (in press; 1994). For the first interview, I had compiled a list of 8-9 broad statements of questions for me to fall back on in the event of any empty and uncomfortable moments of interaction during interviews. In this sense, these questions and statements were used as a catalyst during interviews. The following questions were used with nurses, doctors and administrators:

Describe a usual day. Tell me about the routines in your day.
Do you need to plan at all? How do you plan (priorities)?
Who do you work with?
Who do you talk to / have contact with?
What changes are being made? Who supports you?
What about priorities / how do you set these?
What gets left out when it's too difficult to do everything?
What do you find most surprising?
Can you tell me about an incident that gave you the most pleasure working here during the last year?
Can you tell me about a moment which was particularly disappointing working here during the last year?

Some variation of the above questions were employed with patients. The following series of questions were those used during interviews with patients.

Describe a typical day.
What do you do with your time / how do you spend you time?
Do you need to plan at all / how do you plan?
Who comes to be with you/ who do you have contact with?
What part do you play in this hospitalization?
Describe how and when you talk to the nurses and doctors?
What are the priorities / how are these set?
What have you found surprising?

Can you tell me about an incident that gave you the most pleasure during this hospitalization?
Can you tell me about a moment that you found most disappointing during this hospitalization?
Outside network / commitments external to hospital?

The semi-structured approach resulted in variations on the themes of these statements and questions. Another way of characterizing the interviews is that the interviewees did most of the talking. This semi-structured approach permitted a flexibility to accommodate different topics of discussion raised by the interviewee. Schatzman and Strauss (1973) describe such flexibility as a conversational approach:

> The interviewer does not use a specific ordered list of questions or topics because this amount of formality would destroy the conversational style. He may have such a list in mind, or even in hand, but he is sufficiently flexible to order it in any way which seems natural to the respondent and to the interview situation. After all, what does one do when the respondent, while answering the first question, fully answers the third and sometimes questions six and seven? Far from being disorganised by this state of affairs, the interviewer builds upon what has apparently become a shared event. Conversation implies this very property (1973, p. 73).

As noted above by Schatzman and Strauss I did not use all questions for each interview. I commenced interviews typically, with a question/statement like: 'Describe a typical day' (or some variation such as 'What's a usual day for you?'). This resulted in interviewee's identifying activities and contacts which they had on a day-to-day basis. Many would respond with 'Well let's take yesterday and I'll tell you what I did - would that be okay' (or 'I'll tell you what I have done so far today'). After commencing their response, frequently interviewees would ask "Is this the kind of thing you want to know ... is this okay?" or some variation of this question. Following my general statements and questions responses from interviewees occurred, which I then used as the basis for framing subsequent questions. The aim of the first interview was to obtain an account from the interviewee of their day-to-day work practices (Melia, 1987; Oakley, 1981). The semi-structured approach utilized during the first interview enabled me to collect a range of issues and information accumulating a large data base for subsequent analysis. Several interviewee's comments included: "how good"; "therapeutic"; interesting"; suggesting that "it is good to talk about these things" during interviews. This suggests that taken-for-granted day-to-day activities are not a topic commonly used by interviewees in their discussion with other members of Bestcare on a routine basis (ie. "it feels good to talk about all this stuff" and "I don't get the chance to do this"). The discussion now turns to distinguish the format of the second interviews from the first which were conducted with all interviewee's.

Second Interviews

As noted, each interviewee was interviewed twice. The second interview enabled me the opportunity to cross-check and clarify information obtained from each interviewee's tape-recordings. The second interview also enabled me to follow up other lines of information as seemed appropriate. Like

the first, all second interviews were tape-recorded and transcribed following the collection of research material.

At the time of the second interview I presented the interviewee with a summary of the first interview. I took this summary from notes I had made during the first interview and direct quotes taken from the tape-recording of the first interview. Each interviewee was presented with a list of themes which arose from the content of the first interview material. Each interviewee was asked to prioritize these themes (arising from the content of the first interview) but identified by myself. In addition, each interviewee was invited to add or delete themes on the list provided by the researcher. Some interviewees added items but none were deleted.

The use of prioritized lists from the second interviews acted as indications of what members espoused to be important in their day-to-day activities and this directed me to collect research materials which supported claims made or that refuted 'espoused' priorities of day-to-day affairs. During the second interview I occasionally fed topics and questions back and forth amongst interviewees. For example, the topic of primary nursing was raised by some nurses during first interviews. In some cases, I then fed the topic of 'primary nursing' during the second interview to other nurses who had not raised it to obtain their comments. In this way information gained from one member was posed as a question to another interviewee. I suggest that this is an example of reflexivity and not analysis. This contrasts with the view taken where grounded theory as a method is employed and is addressed later in this Appendix.

First and second interviews occurred as close together as possible, however in order to accommodate the schedules of interviewee's these periods of time did vary. For example, all patient's first and second interviews occurred within a three day period. Nurse's interviews varied between one day and eight days. First and second interviews with doctors occurred within a five day period while administrators varied between three days, and in one case there was a three week period between the first and second interview. This occurred as a result of pre-scheduled vacation time for the interviewee.

Interview accounts were conducted in tandem with observational periods and acted to reinforce or sometimes provide direction for observational periods or interviews. For instance, one interviewee identified his/her concern of a current practice of one nurse conducting a family assessment while another nurse would write up the formal account in the patient's chart. In clarifying what the interviewee meant, this lead me to conduct observational periods of family assessments.

Use of examples

During both first and second interviews I requested examples. As interviewees talked about their day-to-day activities, if not forthcoming, I would ask for an example. The use of examples enabled placing topics or matters of interest raised by interviewees in a historical context. Examples enabled a frame of reference to time such as "yesterday" or "last month". Hence one of my aims was to situate general statements within a specific instance(s). The use of examples also resulted in interviewees being reflective and discursive. For instance, interviewees stopped themselves in identifying other 'rationality's'

(Garfinkel, 1967) to a particular situation in saying "like I was going to say but ... no, in thinking about it ... it was more like..." or "just in hearing myself now, and thinking about it ... it was like" (Garfinkel and Sacks, 1986). This suggested interviewees had not previously considered the topic at hand in the way they were recounting it at that particular moment and time. In the above noted ways, the use of examples during interviews facilitated the conduct and situated character of interview material. However, I would also like to suggest that content from interviews did not only comprise 'espoused' comments about day-to-day practice. I suggest discussions in the thesis show that interviewees' accounts were also reflective.

One final comment pertains to the use of examples. By providing examples interviewees disclosed details on an intimate level of reflection. In several cases the interviews conducted provoked sensitive issues. Brannen (1988) recommends allowing an member's account to emerge gradually and 'on the terms' of the interviewee. This also cross-links with employing 'critical incidents' (Flanagan, 1954) in writing up interview accounts (to be addressed shortly). First however, in contrast to Witkin (1993) who utilizes 'critical encounters', and the suggestion to direct interviewees to 'stop' when he perceived they had said enough, I did not interfere with the interviewees commentary. Also in contrast to Witkin, and also Oakley (1981) and Brennen (1988), I suggest that 'sensitive' issues are not entirely confined to personal decisions and experiences such as abortion and motherhood. During interviews, interviewees discussed their day-to-day work with varied emotional expressions including tears, frustration, and anger. In the interviews that I conducted an array of topics are not those privileged as issues deemed to be 'sensitive' such as those mentioned by Witkin, Oakley and Brennen. The emotions displayed by interviewees in this study suggest that these members take their work very seriously and it is a mistake to privilege 'sensitive' topics over day-to-day struggles in the workplace (ie. performance appraisals, credit taking, differences in opinions about work issues from member to member and so on). Several interviewees 'thanked me' for taking an interest in issues which were important to them. Such occurrences correspond with Witkin's (1993) suggestion that in-depth interviews "can sometimes have the same personal effect on the subject as a therapeutic interview" (p. 18). As noted terms such as "good", "therapeutic", "it is good to talk about these things", "interesting" and the like were identified by interviewees following the first and second interviews.

Documentary material

The third source of research material gathered from this hospital was documentary material. The purpose of obtaining such documents was to review written forms of communication generated by and available to members Bestcare, patients and general members of the public. Documentary material is intended to reflect the conduct of hospital practice and what members say happens. Similar to interview accounts, a documentary source constitutes formalized organizational practices and are included in what Argyris and Schon refer to as 'espoused-theories'. As with interview accounts documentary sources provide a cross-check for the practices observed to occur within the hospital premises. Hodder (1994) provides a recent review of written sources and Rosenthal, et. al., (1980) exemplify researchers who supplement observation and interview material in a hospital.

During the course of the collection of research material several nurses, doctors and administrators suggested and provided resources which they perceived may be of interest to me. They willingly provided material including reports for the Hospital Board, reports of physicians, nurses and administrators. Other volunteered resources included copies of minutes of all the meetings which I attended within Bestcare. This practice was in line with others (nurses, doctors and administrators) who attended meetings. Similarly, memorandums for the schedules of all meetings were given to me.

On other occasions I initiated requests from interviewees based upon information they imparted during the course of interviews and contacts that I had with members throughout the period of research material collection. In addition to meeting minutes, brochures for patients, care plans, teaching handouts, performance appraisals, organizational charts, departmental policies and procedures (short term and long term goals, codes of practices), annual reports, budgets, labour relations documents across the organization were obtained. Each documentary source that I requested was provided.

Access to patient charts was not requested and not used. However, as discussions with administrators indicated, this would not have been problematic had I requested such access. Garfinkel's study on 'good organizational reasons for bad clinic records' (1967) exemplifies the claim that charts should not be viewed as reliable representation of practice. Instead they are second hand representations of empirical reality and contrast with Van Maanen's and Mintzberg's emphasis on 'first hand' representations. In another case, Raffel (1979) shows how recordings in patient charts constitute one form of day-to-day practice; a representation of what members writing in such charts want to construct about their work. However, such representations do accomplish a view of day-to-day organizing arrangements. The difference is important. Raffel provides the following example from a patient's chart which is frequently used to 'represent' long periods of time:

11:00 - 07:00	Slept well.
11:00 - 07:30	Medication given for sleep. Appears to have slept.
07:00 - 03:30	Had shower. Out of bed walking.
03:00 - 11:30	Continues to improve (p. 67).

This charting is intended to represent what happened to this patient during an entire 24 hour period. I suggest the above recording speaks about events which have ostensibly occurred and are presented above as an 'outcome' which raises more questions than it answers. In terms of Cooper and Law's (1994) extensive discussion comparing proximal and distal orders of organizing, the above represents a distal (outcome). My position is that the patient chart represents a formal account of what members (ie. nurses and doctors) report on and relays that in accordance with hospital policies. Nurses frequently make notations in patient charts for activities with which they have not been involved. I observed such activities and nurses freely discussed such practices in four different wards where I collected research material. An instance of this was cited above in relation to the conduct and recording of family assessments. Finally, where an examination of practice is at issue, as a social accomplishment, observing empirical reality 'first hand' is required to provide the 'ethnographic presence'.

The aim of this research is to draw from the best possible representations of practice; these are not adequately reflected in hospital charts.

Integral to the development, conduct and analysis of this project has been a concern with ethics, validity and reliability. I now turn to address informed consent.

Informed consent

Verbal consent was obtained informally when interviews were scheduled. Written consents were obtained prior to the commencement of scheduled interviews. A duplicate consent form was supplied to each interviewee. The interviews all took place at Bestcare. All members who I approached for an interview consented to be interviewed.

The same method of duplicating consent forms was used for observational periods conducted inside patient rooms. In addition, the hospital ward had a consent form in place that was viewed by Senior Management and Middle Management to cover my research work. To explain, all patients attending particular groups on the ward were required by the Hospital to sign this consent prior to patient attendance. This consent was routinely employed by nurses in their work with patients on this particular ward. Importantly, throughout the collection of research material, I was aware of the fluctuating states of acutely ill patients and their family members during periods of hospitalization and maintained sensitivity towards their capabilities.

I discussed my general plans for observation with nurses on a day-to-day basis and conducted interviews with nurses as agreed by interviewees. On a couple of occasions interviews were interrupted for a few minutes to enable nurses to tend to requests originating from the ward. The relations between nurses and myself were such that open and informal interaction characterized our contacts. Several nurses approached me with items that they felt I might be interested in throughout the collection of research material at Bestcare.

Researcher's conduct

The reception from patients was also conducive to the collection of research material. For instance, within the first couple of days of the commencement of my project, I had through one activity or another been introduced or introduced myself to several patients on the ward. After the first couple of interviews with patients they took it upon themselves to 'spread the word of my presence' and their perceptions of 'what I was up to' on the ward. In some cases, patients initiated introductions between myself and 'newly admitted patients' on the ward. Following interviews or some type of contact with me during routine activities on the ward, patients approached me and offered addendums to questions and responses arising from interviews.

The response from members (nurses, doctors and administrators) throughout the hospital was one of enthusiasm. This enabled the smooth conduct of this study. In addition to the formal interview contacts, informal discussions occurred in the main lobby of the hospital, in the cafeteria and

lounge areas as we happened upon one another. Administrators expressed interest in me accomplishing my collection of research material and made general inquiries about other members assistance with my general aim. In this sense informal interaction was constituted as occasions when members of Bestcare would recall for me activities that were 'up and coming' within the site. Efforts that Senior Management made to announce my arrival within the hospital likely affected the ease with which I was permitted access to hospital activities and material.

One specific type of activity which was slightly more difficult to access was interaction between nurses and patients referred to by persons on the ward as "one-to-ones". As a discussion of the research material shows, such interaction is disproportionate to other activities which I was able to access. However, the reason for this difficulty is that such activities did not occur as regularly as nurses suggested they occur during the time that I collected research material. Altschul (1972), Macleod-Clark (1982), Cormack (1976) and Gordon (1986) also indicate that one-to-ones between nurses and patients do not appear to occur as frequently in day-to-day practice as is espoused (claimed) by nurses. As the discussion of research material shows, nurses explanations for 'not conducting one-to-ones' with patients are varied.

An important aspect of the collection of research material was being flexible. As already noted scheduled interviews were agreed upon and pre-specified with interviewee's in advance. However, for the rest of my time I was available to activities occurring on the ward and within Bestcare. Hospital administrators allocated me office space (and telephone) near the geographical location of the ward which enabled affiliations with patients, nurses, and other members at Bestcare. In this way, members approached me and informed me of changes in planned activities, admissions of patients to the ward, or activities that they felt I might be interested in when I was not 'on the ward'. My availability and flexibility was met with a level of assistance from members at Bestcare.

Textual reliability

Observational material was recorded at the time of the observation periods. Textual reliability of interviews is enhanced by verbatim transcripts (Field and Morse, 1985; Mintzberg, 1979b; Parse, et. al, 1985). Interviews were audio-tape recorded and transcribed verbatim. The study was designed to allow each interviewee to validate a summary of the transcripts during the second interview. This occurred to provide a cross-check that the research material collected during the first interview was accurate. All interviews were conducted within the hospital which enhances the receipt of context specific information. I carefully constructed my 'text' representing empirical practice which then grounded my disciplined interpretations. Textual reliability of findings is enhanced by returning to the preserved research material ('raw data') rather than interpreting previous interpretations.

The extensive periods of observation lend themselves to being familiar to those being observed to circumvent members putting on special performances for a researcher. Obtaining a cross-section of interview accounts from members in different geographical areas of the hospital guards against a

one-sided perspective and enables a cross-checking of research materials during the analysis.

One way of meeting criteria of validity is to demonstrate the descriptive validity of the findings through their plausibility to others (Czarniawska-Joerges, 1992; Cohen, 1987; Putnam, et. al., 1993; Germain, 1986; Atkinson, 1990). In this way, plausibility is displayed by the descriptions and explanations provided. Van Maanen (1993) suggests the goal is to provide an account:

> that can be read and understood by many people, with and without ethnographic interests. The documentary intent is to convince readers that the portrait is a good one (p. 223).

The plausibility of this study is provided for the reader in the discussions of Chapters 3-8.

It is also important to acknowledge that I can never know or understand completely about another person or their activities. I conducted the collection of research material enabled (by accessing and obtaining members everyday understandings/knowledge) and constrained (by limitations of these particular forms of 'knowing' or 'understanding') which facilitate a partial view of an empirical site.

Guarding against premature interpretations

The aim of the collection of research material was to 'get into' Bestcare to collect research material which would later be analyzed (Putnam, et al., 1993). In order to reduce the chance of 'compromising' the integrity of the empirical material by prematurely analyzing materials, analysis was deferred until all material was collected. As planned, my analysis of the research material occurred following the data collection period. Having made a text, the hermeneutic task is to keep returning to that text.

An opposing approach, to analyze research material on an ongoing basis could compromise the integrity of the research material. Law and Lodge (1984) suggest that "we lose information" when the aim is to identify similarities amongst situations which 'were' unique (p. 22). Hence my approach contrasts with a grounded theory approach where an aim to 'make similar' or generalize interpretations as the conduct of research material occurs.

Furthermore, given the importance of being flexible and readily available to activities in the empirical setting, in concert with observation and interview activities which were ongoing, analyzing while in the collection of material was occurring would have been impossible. In this way, my own time and resource limitations together with the volume of material required for this type of study prevented analysis. Retrospectively, I cannot see how I could have conducted both aspects of the research process simultaneously. In a vicarious sort of way, not expecting to conduct analysis during the time of research material collection absolved me of this problematic and enabled me to concentrate on the activity at hand, that is, the collection of research material from the empirical site. Rather than being preoccupied with findings I was able to focus on a pressing part of the research process, the collection of research material. However, suspending formal analysis until research materials are all

collected does not negate my ongoing reflective state (or what some readers may identify as a type of informal analysis) on a day-to-day basis while collecting research material.

Retrospective account of analysis

Here the pragmatic aspects of the process of analysis employed for this study is identified. A log was kept during the data collection to identify tape-recordings and observation periods. A chronological approach was employed to tabulate the day-by-day and week-by-week hours of research material collection (observational accounts and interview accounts) with completed transcriptions and times. The observation material which had not been transferred to computer was completed. Each audio-tape for observational and interview accounts were systematically transcribed, read and re-read in the order that the research material had been collected. Each transcribed interview and observational account was re-checked for clarity and precision in order that the representation is as accurate as possible which subsequently stood as *the preserved text* Documentary sources were re-read and collated for later access. These labour intensive activities enabled me to establish accuracy of the text form of research material. These activities also enabled me to re-familiarize myself with the research material obtained.

Next I centred on the observational material which comprises the centre of my study. This material represents a view of practice in this site. Each day's observation material was read line-by-line and page-by-page. After having read through all of the research material I began writing. Subsequent readings enabled distinctions of similarities and differences between actions taken in one case and reflecting that back on other activities. I interacted with the material by posing various questions and lines of inquiry to the observation material.

Initial readings were aimed at identifying patterns, themes and striking notions about interaction and activities guided by a number of underlying questions. For example, 'how' work occurs on this particular ward; who does the work; what does the work consist of; who is informed about the work that went on; how they are informed about the work that went on; and where does the work occur. As expected, during this analysis of the research material it became apparent that patient participation was not practiced in the ideal ways referred to in extant literature and therefore the conditions enabling and constraining potential activities required a more detailed examination. It became important to raise the taken-for-granted organizational arrangements as problematic which enabled a more critical approach.

Amidst these readings of the observational material, the approach I took shifted and became less and less systematic compared to the previous form of line-by-line, page-by-page approach. Instead, there was a backward and forward movement through the observation material which was driven by following up certain lines of actions which heightened the interactive character of my readings. For example, particular language-in-use (terms) of patients and nurses and the ways in which say nurses would use the same term to refer to a variety of notions were identified.

The fluidity of my attention to the research material raised contradictions of actions (members and groups of nurses, patients and other

health care providers) constituting day-to-day practice on this ward. Activities revealed ambiguous and stable actions of members. An interplay of the interview accounts and observation material occurred as I attempted to write up my view of what keeps the day-to-day going in this ward. Another way of characterizing my approach to analysis was to try to identify an embedded story line which anchored particular lines of inquiry taken (Van Maanen, 1993). The lines of inquiry taken could be referred to as 'hypotheses' which were examined in light of the observation material. During these periods I moved back and forth between observation and interview material. Potential story lines were disciplined by my returning to read with 'new' understandings the preserved observation material.

Nurse practices were held up and reflected against patient practices and vice versa. After establishing recurrent practices, the inquiry began to reveal where such practices originate from; and how they are 'passed on'. Questions such as: 'Does this occur in the same or different ways for nurses with nurses compared to nurses with patients and patients with patients?' Questioning the observational material and posing the conditions around which practices occur in the empirical material emerged. Fed into the emerging view of day-to-day ward practice were similar questions of doctors and administrators accounts.

In this regard, another period of time was devoted to examining the interview accounts separately. Perhaps because of the volume of material I concentrated on the interview accounts and documentary material. A focus on these revealed further similarities and differences, contradictions or 'absence of fit', in the day-to-day practices on the ward. For instance, what nurses and patients 'say they do' (from interview and documentary accounts) was compared with that which they have been 'observed to do' in day-to-day practices (observation). This 'systemic' form of analysis triangulates research material. In this way, analysis takes on a more extensive (expansive) view in terms of the research material collected. Again contrasting and making sense of discrepancies emerging from different types of accounts and research material reveals opposing and complementary organizational arrangements.

My position in the conduct of an ethnography is that it is not about evaluating practice. This is what Mumby (1993) refers to as "the failure of ethnography" and suggests that "many ethnographic studies reaffirm managerial orientations by falling into the trap of being value neutral" (p. 225). The point about 'neutrality' may bear repeating; neutrality is not possible. However, as the discussion of research material shows, this ethnography does not fall into the category of 'reaffirming managerial orientations' as Mumby suggests. Furthermore the aim of this study, aligns with an ethnographic approach and thereby is not to evaluate what goes on in day-to-day practice as 'good or bad' practice. Importantly, the aim of this study is to show the 'how' and 'what' of practice and 'the products or effects of ordering or organizing' (Cooper and Law, 1994) which sustained conduct has on its members (which they in turn draw from to reproduce their activities). Another way of phrasing such an aim is to identify 'what members do and how' members mobilize one another (or 'move' one another) in daily hospital affairs. This enables a focus on what **is** happening rather than shifting to suggest what **ought** to be happening. Frankenberg (1980) suggests that an important aspect of analysis is to offer 'explanations about the articulation of levels of social interaction'. He appears to be underlining the importance of explicating how there is an interpenetration of day-to-day practice across distinguishable spaces of work. I stand against providing an 'evaluative frame of reference', including the

crescendo with a chapter of recommendations about practice in this hospital: the reader will make his/her own readings of this ethnography. In keeping with this aim, this also sustains my purpose for conducting this research as provided to members of Senior Management during the negotiation of access for this research project.

The approach to analysis taken here is also distinct from the chronological and systematic analysis of categorical themes as the linear device where all themes and notions fit into established categories. The themes identified in my project were played off one another in the empirical material rather than being theorized about outside of the empirical material. Thus the approach to analysis employed here is distinct from that of Glaser and Strauss's (1974) constant comparative analysis arising from Schutz's phenomenological sociology.

It is important to distinguish this difference. Constant comparative analysis is a technique used to categorize 'incidents'. The categorization is an analytical device used by researchers to reduce incidents into similar and dissimilar categories. These abstractions of the 'raw data' comprise the pieces ultimately towards developing a theory. The aim of a constant comparative analysis is in developing a theory. Glaser (1978) suggests that the study can be concluded when theoretical completeness is achieved. He suggests that this point is reached when the researcher:

> explains with the fewest possible concepts, and with the greatest possible scope, as much variation as possible in the behavior and problem under study (p. 125).

This exemplifies a level of abstraction that is required of a constant comparative analysis which does not enable the types of accounts that are expected to require re-visiting following the collection of research material. Thus such an approach stands in opposition to the aims of this research project. Inherent in my approach is a concentration on the 'text'. My approach is distinct from the grounded theory method in the rigour invested in the movement not only to return to the 'text' but in returning to the 'text' (a return to the observation material and interview transcripts) again and again. While re-visiting the 'raw data' can never constitute a fresh start, each re-visit is informed by new understandings.

Again in contrast to constant comparative analysis where the process of categorizing occurs from the second interview and constantly accumulates based on the identified themes originating from such an account; the approach taken with my study was to accumulate an array of observational, interview and documentary material which were analyzed following the completion of the data collection phase. This protects against prematurely identifying a category which a researcher is subsequently stuck with, ultimately limiting the type of information recorded following the identification of a category. Empirical details which are collapsed into one category and subsequently set aside in favour of a more suitable category requires dispensing the empirical data in the previous category which has been replaced.

Moreover, refraining from analysis of the research material provides for returning to the 'raw data' in it's most precise (preserved) form. As the analysis from this project reveals reading and re-reading 'raw data' provide for new understandings and new understandings of those new understandings upon

future readings of the data. Not having the original 'raw data' to return to precludes such analytical understandings and research would be conducted on more of a feed forward direction. The approach taken here is one way of ensuring that that which arises from my interpretations is based on the 'raw data' rather than some constructed abstraction or re-construction of the activities in the empirical world. Furthermore, the approach taken here permits cross-checking of my interpretations by other researchers based on 'raw data' rather than re-constructions of the empirical phenomenon.

The difference between these are of vital importance in research. These distinctions are pivotal in an examination of empirical reality. Moreover it is necessary to sustain a sensitivity to the specifics in empirical reality. In contrast to a model/theory approach to practice such as Peplau (1988/1991), I stand against universalizing. In attempting to universalize, to titrate the differences into 'same-ness' Peplau aims to package the 'same-ness' and so proceeds to generalize. Once details are packaged into 'similar' (or dissimilar) this puts her in a position (of power) to predict. While all research requires generalizations I aim to be sensitive to the specifics rather than attempting to dismiss specifics as mere instances (Cohen, 1992). Importantly, details cannot be dismissed as merely isolated incidences. And explanation, not prediction, is where a sensitivity to the specifics can propel research. As shown in Chapters 3-8, explanatory power is an effect of the specifics.

Theorizing methodologies

It may be useful to discuss how analysis progressed in the current thesis. Here I present one way of examining conceptions of day-to-day practice which is embedded in the day-to-day patternings of relations. In this sense relations or patterns are waiting to be explicated. As noted in this thesis, aspects of community appear to sustain day-to-day practice. Once such a view arises, this opens up sets of available coordinates of community (spatial orderings) which are readily associated with community to be reflected upon. It also follows that such associations suggest other potential relations. This underlines how forms of extending that which is known can be gained by altering the focus. Among others, Strathern (1991) presents such analytical devices identified as domaining and magnification. She states that domaining is:

> the observer's facility to move between discrete and/or overlapping domains or systems, as one might move from an economic to a political analysis of (say) ceremonial exchange (1991, p. xiv).

Strathern describes magnification which also helps elucidate aspects of day-to-day practice. Magnification includes:

> the facility to alter the magnitude of phenomena, from dealing (say) with a single transaction to dealing with many, or with transactions in a single society to transactions in many (1991, p. xiv).

Such a view overlaps with how Strathern explains relations and connections, in that, phenomenon "can appear in new configurations as one transfers from one domain of enquiry to another" (p. xiv). The important point is that both of these terms (domaining, magnification) used by Strathern change the focus (using associated terms) which in turn helps to create space for detailing aspects

of practices being investigated. As will be discussed shortly, Morgan (1986) accomplishes similar aims while he identifies the analytical tool of metaphors.

Another way of phrasing this unravelling of ethnographic material is developed as Strathern references Thornton, who identifies "a branching or bifurcating of concepts" (1991, p. xvii) while Rose and Miller (1994) suggest a similar process as they refer to "reticulation: the formation of networks" of terms (p. 59). In each case what is suggested, is that discourse is composed of a series of congruous or related coordinates. Such a network or labyrinth acts to set in motion a series of associated terms which can be reflected upon during (say) analysis. So to extend a view of persons as nurses, persons as patients, persons as members and persons as individuals, I employ analytical devices to change the focus and examine aspects of community which appear to be already there. For instance, in order to examine how aspects of community (ie. members, membership, matters of interest, affiliation, belonging) are constituted, changing the focus helps to examine the production of, for instance, membership in day-to-day practice. Thus congruous and associated terms help to make extensions (and fill the gaps of what is know and how to develop understandings of day-to-day practice) of persons constituting day-to-day practice.

In the current thesis explicating community as that which sustains day-to-day practice on one ward was only one aspect of analysis. Community as a social accomplishment is sustained by more than one single relation or relationship (there are replications of several forms): a variety of relations and relationships must be being performed in particular ways at particular times. In order to examine whether community held across various interaction between patients, nurses and so on, it was helpful to employ aspects of what, as previously noted, Strathern refers to as domaining and magnification. Here aspects of community appeared to emerge from ethnographic material. From person to person and interaction to interaction these aspects of the day-to-day weave in and out of ethnographic material. For current purposes, I will elaborate using one aspect of community, membership, which is relevant to the current study.

Once membership was explicated as significant for day-to-day practice in this site, further issues pertaining to membership were posed. Membership does not emerge from each and every part of the ethnographic material and, in this sense, its relevance expands and contracts throughout the ethnographic material. Explicating issues of membership provided a focus which in turn opens up space for more detailed considerations. For instance, what emerged from ethnographic material is that further details of interaction revolved around inclusion / exclusion practices and the provisionality of membership in day-to-day practice. It is important to note that digging out aspects of community was anything but a straight forward process. Rather, this process involved a back and forth movement between types of ethnographic material and emerging figures in day-to-day practice. In spite of what I was finding, the view that community does hold day-to-day practice together was suspended until all of the material had been analyzed (for further discussion of methods and analysis see Chapters 1 and 2).

As previously noted, ethnographic material conceals and reveals a view of how relationships between an image of a person as a member of community and an image of an individual in an organization appear. Each of the former images are open to relations with other notions within congruous or associated

configuration of terms (spatial orderings). Also, "each configuration of concepts produces a remainder that generates a new dimension" (Strathern, 1991, p. 108). On one hand, to concentrate on an image of a member, notions of belonging, affiliation, membership, matters of interest, infer a potential fit of associated terms, to conceptions of members of a community. On the other hand, notions of belonging, affiliation, matters of interest do not sit unobstrusively alongside an image of the individual in an organization. In this way, it is also important to note that, while congruent and associated terms enable some images, other images and readings are closed off.

Just as associated terms help to identify conceptions of congruous coordinates of phenomena, they also close off relations to notions typically conceived of as outside that particular image. For instance, to refer to information systems as formal organizational practices of individuals and also refer to cultural practices of members, reveals two disassociated modes of ordering which appear at odds with one another (an example of this is discussed below). Orderings, enclose readings, and in so doing, reveal how theorizing is being developed. Such theorizing reveals the position of speakers/writers which in turn, locates for the interactant/ reader some instances of the places and spaces of pre-figuring. Pre-figurement of persons as members or as individuals demarcates aspects of practice which I try to connect to.

To exemplify how the above depicted analytical process works I present some relevant literature.

Images and metaphors

As previously noted, images (metaphors) and the use of congruent or associated terms work to open up views, but they also work to enclose views. I have presented the importance of such analytical devices in an effort to help explicate how understandings of day-to-day practice emerge. Here I wish to draw attention to sustaining a consistent perspective and this relates to Morgan's (1986) discussions of images of organization using metaphors.

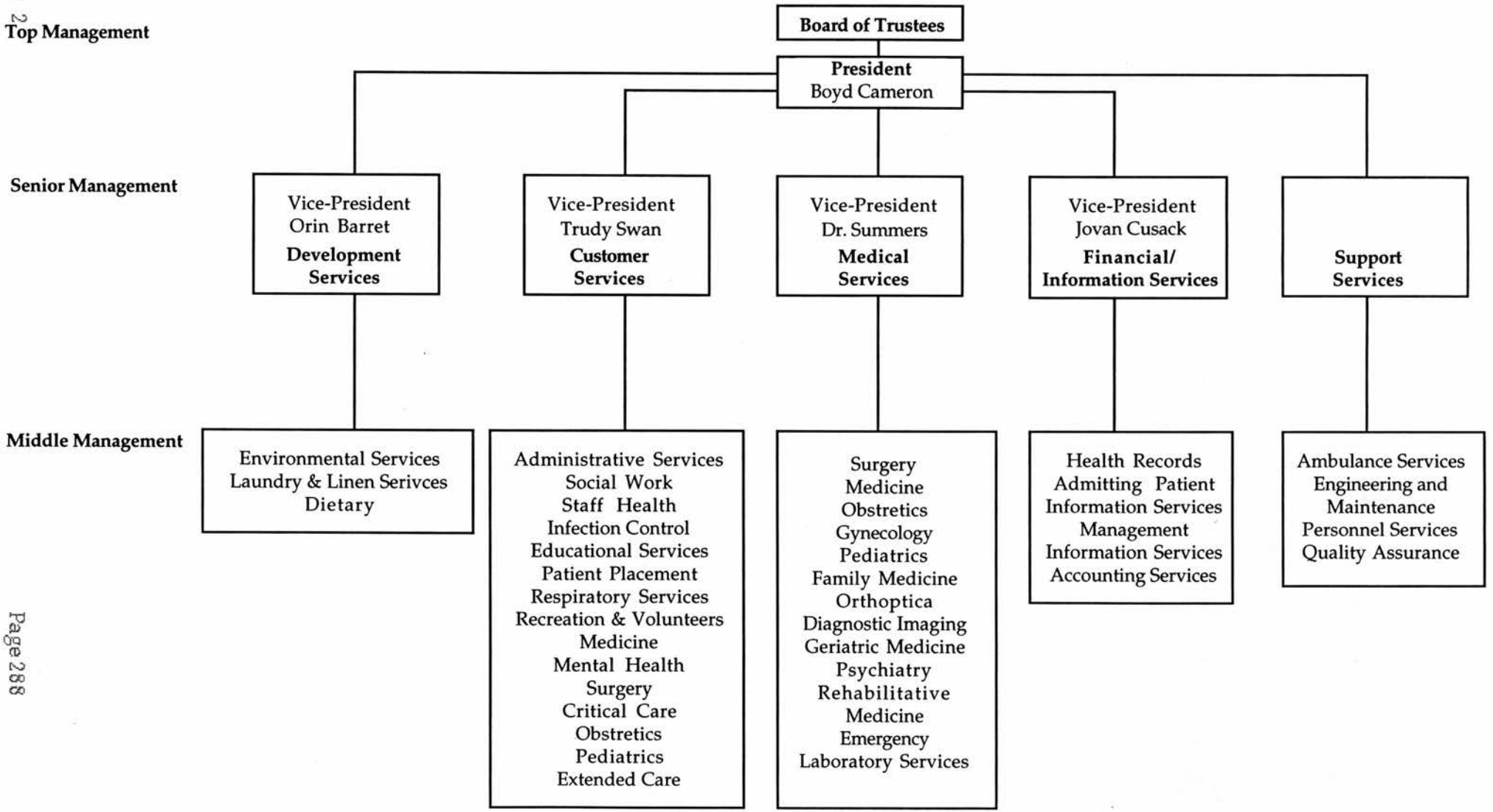
Morgan identifies the effectiveness of employing different images of organization. He describes how extensions are made possible through employing, different metaphors such as machines, organisms, brains, political systems, cultures as so on. It is the image which helps to make 'stable' analysis. In a similar way to that of Strathern (1991), Morgan presents examples of how apposite configurations of one aspect can be expanded upon and lead to further understandings that underpin a particular view. These different patternings or series of related notions enable, as well as, constrain (or close off) readings of day-to-day practice. In this respect, Strathern (1991) stresses that there are limits and states that "no one perspective offers the totalizing vista" (p. xvi).

I now take an example which cross-links with my thesis. While employing culture as an analytical tool to elucidate some aspects (such as kinship relations or affiliations among persons, rituals, ceremonies, shared expressions, stories, artefacts, boundaries) of day-to-day practice in an organization, other readings and aspects of day-to-day practice are missed (matters of interest, voluntary aspects of day-to-day, information systems, discipline and self-discipline, formal and informal organizational practices) because of the absence of fit. Taking the above example, then, there is a

movement along terms: terms almost systematically divide a series of exchanges and associations which can be addressed within any particular view. In order to extend a view provided by any particular metaphor (say because of constraints) then a switching of perspectives (from one metaphor to another) is required. Through the use of metaphors, Morgan addresses the appearance of different figures in viewing an organization as a culture or a political system. Morgan addresses difficulties when extensions are made beyond relevant systems of distinctions (metaphors, images or figures). I draw attention to Ouchi's (1979) work, also from the organizational and management literature, to illustrate a case in point.

Ouchi crosses over and switches perspectives. In particular, he refers to aspects of culture but seeks to do so in information terms. As already noted, referring to aspects of day-to-day practice in one domain (culture) is not helped by explanations from another domain of understandings (cybernetics). Ouchi treats formal and informal organizational practices as separate entities. He then goes on to describe informal practices using terms typically associated with information systems. By switching perspectives, Ouchi sets up an incongruous argument. He talks of culture (one domain of understanding) and mixes this up (with a different domain), in information terms. It this way, Ouchi reveals in his writing an example of someone attempting unsuccessfully to escape his pre-figurement.

Table 2: ORGANIZATIONAL CHART



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